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JFMA

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC. JANUARY 1972



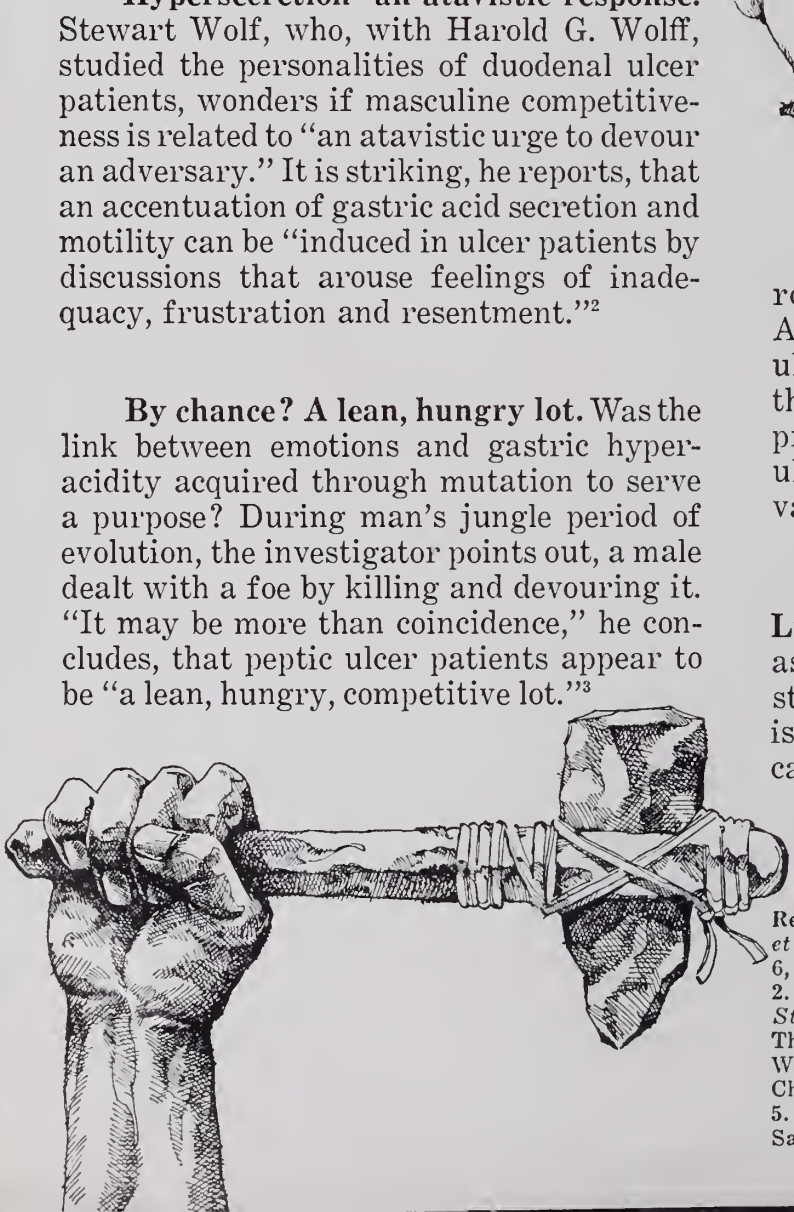
IF MORE MEN CRIE



At least seventy-five out of one hundred adults with duodenal ulcers are men.[1] Why? It may be significant that duodenal ulcer patients tend to crave recognition and are "especially vulnerable to threats to their manly assertive independence."[2]

Hypersecretion—an atavistic response. Stewart Wolf, who, with Harold G. Wolff, studied the personalities of duodenal ulcer patients, wonders if masculine competitiveness is related to "an atavistic urge to devour an adversary." It is striking, he reports, that an accentuation of gastric acid secretion and motility can be "induced in ulcer patients by discussions that arouse feelings of inadequacy, frustration and resentment."[2]

By chance? A lean, hungry lot. Was the link between emotions and gastric hyperacidity acquired through mutation to serve a purpose? During man's jungle period of evolution, the investigator points out, a male dealt with a foe by killing and devouring it. "It may be more than coincidence," he concludes, that peptic ulcer patients appear to be "a lean, hungry, competitive lot."[3]



Big boys don't cry. If more men c maybe fewer would wind up with duod ulcers. But men will be men—the sum tot their genes and what are taught. Schottst observes that wh mother admonishes son who has hurt hin that big boys don't cry is teaching stoicism.[4] Crying i negation of everyt society thinks of as ma A boy starts defendin manhood at an early

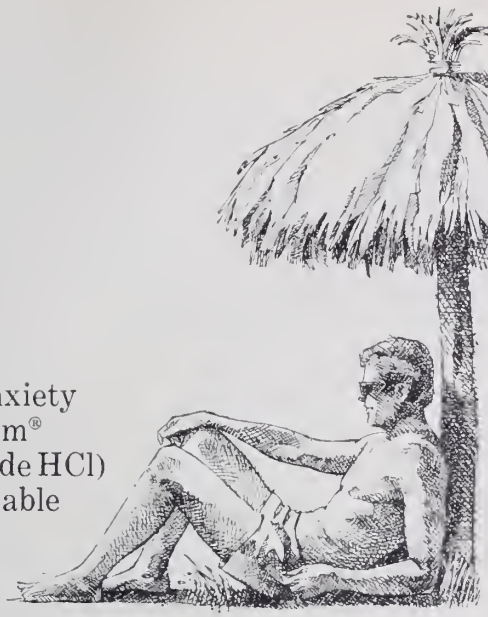


Take away st you can take away sympt

There is no question that stress pla role in the etiology of duodenal ul Alvarez[5] observes that many a man wit ulcer loses his symptoms the day he shut the office and starts out on a vacation. problem is, the type of man likely to hav ulcer is the type least likely to take vacations or take it easy at work.

The rest cure vs. the two-way actio Librax.® For most patients, the rest cu as unrealistic as it is desirable. Still, stress factor must be dealt with. And is where the dual action of adjunctive Li can help. Librax is the only drug that

References: 1. Silen, W.: "Peptic Ulcer," in Wintrobe, *et al.* (eds.): *Harrison's Prineiples of Internal Medici* 6, New York, McGraw-Hill Book Company, 1970, p. 2. Wolf, S., and Goodell, H. (eds.): *Harold G.* *Stress and Disease*, ed. 2, Springfield, Ill., Char Thomas, 1968, pp. 68-69. 3. *Ibid.*, p. 257. 4. Schotts W. W.: *Psyehophysiologie Approaeh in Medieal Pr* Chicago, Ill., The Year Book Publishers, Inc., 1960, p 5. Alvarez, W. C.: *The Neuroses*, Philadelphia, Pa., Saunders Company, 1951, p. 384.



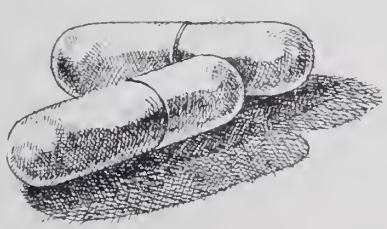
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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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JANUARY COVER—One of the attractions at Florida's newest and most exciting additions—Disney World. Modern-Day Castle rising 18 stories in the center of Magic Kingdom theme park at Walt Disney World is Cinderella Castle, composite of famous French palaces. Only this castle is completely air-conditioned, fitted with escalators and elevators and elegant dining in King Stefan's Banquet Hall. Reproduced by permission of Walt Disney World.

President's Page



Health Maintenance Organizations

With one eye looking to the election year of 1972; and an ear listening to the voice of the consumer, dissatisfied with inadequate, expensive and often nonexistent health care; the Nixon Administration's response comes in the form of a National Health Maintenance Organization, (HMO). The Federal Government has decided that it wants to *keep* people well, because it costs too much money to *make* them well. Hence the concept of HMO.

The Administration contends that the economy cannot support greater annual expenditures for health. The HMO proposal, therefore, would restructure the delivery system around that segment of the population which already has some form of health coverage, including Medicare and Medicaid. This automatically implies that essentially no new money will be available. Although the language of the proposal for HMO does not make it entirely clear, the Administration is apparently injecting into the system a basic element of industrial operation—competition. They apparently wish service providers to compete for subscribers, and they feel that this will aim toward better and more efficient service. Competition does not mean that the Federal Government will tolerate differences in quality, but that the product differentiation is likely to be in terms of benefit packages and of amenities. It is also asking for a complete reversal of the present priorities by putting emphasis on comprehensive preventative services; on early detection and treatment out of hospital. These concepts run counter not only to the present delivery of health services but also to the pattern of medical training throughout the country. I fail to see that the profession is going to be able to adapt itself easily to this shift in priorities.

One of the basic incentives for HMO legislation is the belief that care will be provided more economically. This apparently is based primarily on the reported low rate of hospitalization utilization for patients of existing prepaid groups than for other financing delivery systems. I think it is a fallacy to attempt to apply this principle on a nationwide basis, and so far the data that has been submitted is far from being conclusive. The cost for initiating an HMO must be still considered highly tentative, and where the finances for this type of a start-up program will come from has not yet been decided. I am sure of this—it will be expensive.

From the medical professions' point of view it is particularly important that the HMO itself must take legal responsibility for the quality of medical care. If the HMO is a medical group or foundation, this may pose a problem only insofar as the mechanics of reviewing nonprofessional services are concerned. If, however, a nonmedical agency is the HMO, and it contracts for physicians' services, that agency places the statutory responsibility for quality and appropriateness outside the medical group. This, I think will be intolerable to most physicians.

It is no wonder that the AMA House of Delegates in its meeting in June, 1971, adopted as a statement of policy that the HMO concept is still experimental and unproven as a nationally acceptable solution to problems of health care, delivery and cost; and that the AMA regrets the wide governmental support given this mechanism prior to valid proof of its general effectiveness. Of course, the AMA will continue to study and evaluate HMO's and keep the profession so advised.

It behooves all of us to study this proposed legislation carefully and make our thoughts known through the channels of the AMA and FMA that are open to us.

J. K. Hunt M.D.

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Noble Fowler, M.D., Cincinnati, Ohio
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Caution, very close observation, and careful adjustment of dose are necessary when: insulin is withdrawn during the tria period in order to avoid ketosis, acidosis, and coma; thiazide diuretics are administered which may result in aggravation o diabetic state and increased tolbutamide requirement, tempo rary loss of control, or even secondary failure; treating patients with impaired hepatic and/or renal function and debilitated, malnourished, or semistarved patients in order to avoid severe hypoglycemia which may require corrective therapy over severa days; and treating patients with severe trauma, infection, or surgical procedures where temporary return to insulin or additior of insulin may be necessary. Response to tolbutamide is diminished in patients receiving therapy with beta blocking agents

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cian daily, and during the first month report at least once weekly for physical examination and definitive evaluation. After a month, examinations are recommended monthly or as indicated. Appearance of ketonuria, increase in glycosuria, unsatisfactory lowering or persistent elevation of blood sugar, or failure to obtain and hold clinical improvement indicate nonresponsiveness to Orinase (tolbutamide). Orinase does not obviate need for maintaining standard diet regulation. Uncooperative patients should be considered unsuitable for therapy. Prescriptions should be refilled only on specific instruction of physician. In treating mild asymptomatic diabetic patients with abnormal glucose tolerance, glucose tolerance tests should be obtained at three- to six-month intervals. Orinase is not an oral insulin or a substitute for insulin and must not be used as sole therapy in juvenile diabetes or in diabetes complicated by acidosis or coma where insulin is indispensable.

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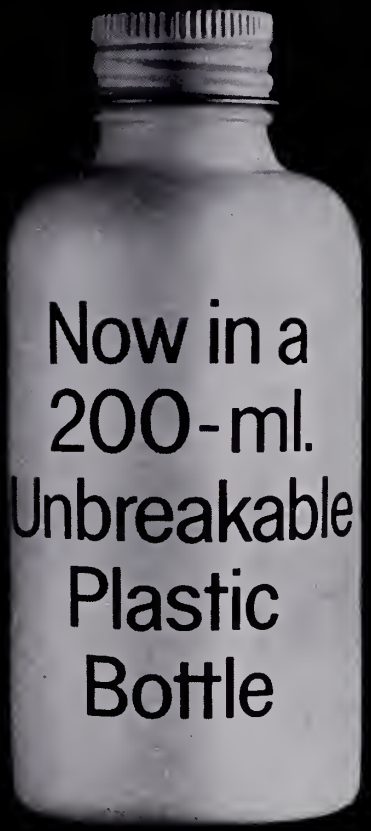
Orinase appears to be remarkably free from gross clinical toxicity: crystalluria or other renal abnormalities have not been observed; incidence of liver dysfunction is remarkably low and jaundice has been rare and cleared readily on discontinuation of drug (carcinoma of the pancreas or other biliary obstruction should be ruled out in persistent jaundice); leukopenia; agranulocytosis; thrombocytopenia; hemolytic anemia; aplastic anemia; pancytopenia; and hepatic porphyria and porphyria cutanea tarda have been reported.

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Evaluating Southern Mental Health Needs and Services

A Preliminary Report

JOHN J. SCHWAB, M.D. AND GEORGE J. WARHEIT, PH.D.

We have just completed the second year of our five-year social psychiatric research project in a southeastern county which is in the throes of social change. The rural-urban shift, black-white confrontation, and deprived-affluent imbalance are evident. Also, rapid population growth, whirling mobility, and the intrusion of modernity are prominent characteristics. In contrast, Alachua County is surrounded by other counties which are showing evidences of declining human and material resources. In these respects, and others too, our research site is representative of many other areas throughout the Southeast.

Our hypotheses center on the impact of culture change on mental health and illness in communities and individuals. We are assessing relationships between sociodemographic factors and "social psychiatric impairment." Particularly, we are concerned with individual and communty responses to processes such as mobility (geographic, intergenerational, and social), the intrusion of modernity (with its breakdown of protective cultural patterns), and marginality. Thus, our theoretical framework is built on concepts of culture change and marginality with particular attention to perception of social change, life styles, institutional changes, and the individual and community responses which are associated with both the amelioration and the development of "social psychiatric impairment." Finally, we are assessing the relationships between these processes and the delivery of health care.

Objectives

Our immediate objectives are to determine, by rigorous research procedures, mental health needs and services and to ascertain prevailing treatment patterns, both existing and emerging ones. Thus, we are conducting a study which will enable us to construct a model for evaluating mental health needs and services. The model will, of course, pass through three stages: descriptive, explanatory, and predictive. The predictive model will be based on a mathematical one such as the Markov Chain Process Analytic Design. Obviously, this work has implications for many other counties and their

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community mental health services. We are designing it so that others will be able to use the model with a view toward modifying or developing their treatment facilities in order to furnish greater services to those who need them.

To build our model, we are using the results from a three-pronged research design: a comprehensive rates-under-treatment study which shows who is currently receiving mental health care; a prevalence study which indicates the frequency of "social psychiatric impairment," and a socio-anthropologic analysis of this area. The results from each of these three major parts will require analysis, evaluation and synthesis so that the model can be constructed, tested and refined.

The data necessary to gain an understanding of the treatment patterns in the county have not been analyzed. When we report on this later in the year, we will be able to describe the kinds of illnesses being treated, correlate socioeconomic factors associated with treatment, and enumerate the various sources of treatment. As part of our rates-under-treatment study, we worked extensively with a large number of community health and welfare organizations including hospitals, clinics and Vocational Rehabilitation.

The socioanthropologic studies will furnish information about the structure of communities, their economic bases, kinship patterns, and primary and secondary group memberships. Importantly, they supply information concerning the individual's perception of illness. This perception of illness is one of the critical factors which has been missing in evaluative studies; it is crucial because the individual's perception of illness determines in large measure whether and when he will seek treatment or services. Knowledge about the individual's perception of illness enables us to understand what leads people to either seek, ignore, or actively reject services.

Procedure for Prevalence Study

Determining the prevalence of social psychiatric impairment in the county required most of our efforts during the entire second year. We were faced with three major problems: sampling, constructing the interview schedule, and rating for "social psychiatric impairment."

Fortunately, we were able to enumerate every household within the county; of the 37,000 we drew a random sample of 2,300 or 6.2%. For the pretest we interviewed 320 subjects; for purposes of validation we also interviewed over 110 psychiatric patients and a separate black community sample of 56. After the pretest was completed and the interview revised for the final time, we obtained an additional 1,650 interviews. Our refusal rate has been low—only 8.2%. Thus, in a 900-square-mile county, with a widely scattered population, we have been able to obtain interview data on over 2,000 persons over the age of 18.

Our interview schedule is designed to show the interrelatedness of our major social and medical variables. These include the family and interpersonal networks; occupational patterns and their correlates such as income, mobility, and life styles; community and societal integration; a medical systems review along with a detailed listing of physical and mental symptomatology; and attitudes toward and utilization of health care delivery. Since the second half of the schedule covers physical, dental, and mental health, as well as attitudes toward and the utilization of services, it encompasses a comprehensive health survey which includes the family as well as the respondent.

From this schedule, we were able to rate for level of "social psychiatric impairment" on a five-point continuum ranging from not impaired to mildly, moderately, severely, or completely impaired. We have established criteria for rating "social psychiatric impairment." These criteria include more than responses to symptom inventories. In fact, the global rating for "social psychiatric impairment" encompasses four dimensions: (1) symptomatology; (2) capacity to function, that is, the ability to carry out the expected social roles and performances consistent with one's age and sex; (3) the quality of interpersonal relationships; and (4) an aspiration-satisfaction index. From each interview schedule a 15-page rating protocol was supplied to three psychiatrist raters who then rated each respondent independently. We found that we had a satisfactory level of inter-rater agreement.

Findings

Health and Illness in the County

From the pretest sample we found that 31% of the respondents were impaired, 80% mildly and 20% moderately (Table 1). Thirty-nine percent of the black respondents were rated as impaired in contrast to 28% of the whites. The females in the sample had higher rates of impairment than did the males, 35% as contrasted to 23%. The relationship between income and impairment was an inverse one; approximately 45% of those with incomes of under $6,000 were rated as impaired.

Only 12% of those with incomes of over $20,000 were found to have any impairment. By age, those under 30 (37%), and those over 55 (38%), had the highest impairment levels. Twenty-two percent in the age group 30-55 were impaired. The widowed (46%), the divorced (40%), and the single (38%), had significantly higher rates than the married (26%).

Table 1.—Social Psychiatric Impairment.

		Impaired	Not Impaired
A. Total Sample		31%	69%
Mildly	80%		
Moderately	20%		
B. Race			
Blacks		39%	61%
Whites		28%	72%
C. Sex			
Females		35%	65%
Males		23%	77%
D. Income			
Less Than $6,000/yr.		45%	55%
More Than $20,000/yr.		12%	88%
E. Age			
Under 30 years		37%	63%
31-54		22%	78%
55 +		38%	62%
F. Marital Status			
Married		26%	74%
Widowed		46%	54%
Divorced		40%	60%
Single		38%	62%

Of the impaired, more than 50% reported that their general health was medium or poor and 85% rated as moderately impaired indicated that their health was not good.

Of the not impaired, 84% rated their health as good; 16% considered it to be only medium or poor. When asked about their health during the last year, about 5% of the not impaired thought that it had worsened while 25% of the impaired thought that their health had deteriorated.

Such evidence of health problems was not limited just to the respondents. Twelve percent of the not impaired and 23% of the impaired reported that other family members suffered from physical disability. Furthermore, 14% of the not impaired and 33% of the impaired respondents reported that other family members were suffering from serious nervous or emotional problems.

Thus, we are seeing that illness and impairment are not randomly distributed; there are clusters of both physical disability and emotional illness within families, indicating the need for comprehensive health care programs for families as well as individuals.

Concurrence of Symptomatology

Large numbers of respondents, impaired and not impaired, complained of both physical and mental symptomatology. For example, minimally 42% of the total sample, 31% of the not impaired, and 62% of the impaired, reported gastrointestinal problems. Almost 20% of the total sample reported feelings that they were going to have a nervous breakdown, 8% of the not impaired and 55% of the impaired reported having such feelings. Thirteen percent of the not impaired and 40% of the impaired were taking psychopharmacologic medications—20% of the total population were using psychopharmacologic medications.

Utilization of Medical Care

About 75% of the not impaired and 80% of the impaired visited physicians during the preceding year. Equal numbers of the not impaired and impaired reported that they had no physicians and equal numbers received no care. Moreover, those rated impaired were not receiving more care than the others—the impaired were getting only as much care as the not impaired. Overall, we found that about 75% of the respondents were seeing physicians; we consider this to be a fairly high utilization rate.

About 16% of the sample, equal percentages of the not impaired and impaired, visited the county health department, again indicating no significant differences in utilization of public services. As expected, many of the impaired were not receiving mental health care from a specialist; only about 12% of the impaired had visited a psychiatrist or a psychologist.

Discussion

From these data, three major findings emerge. First, about one-third of the respondents were found to be impaired, and there is evidence pointing to a significant amount of both physical disability and emotional illness in many of their families. Second, the concurrence of physical and mental symptomatology stresses the necessity for us to think in terms of comprehensive health care. And third, there appear to be no differences in the treatment patterns, including the amount of health care received and the source of care, between the not impaired and the impaired. We conclude that those who need more care are not receiving it. Significantly, only 9% of the not impaired felt they were not receiving sufficient health care in contrast to 31% of the impaired. Thus, there is a differential perception of the need for more health care. Some of the impaired are not receiving care and many of them who are receiving care regard it as inadequate.

Much of our ongoing research will be directed specifically toward those who need but are not receiving services. We believe that this additional research is necessary in order to obtain more understanding of the complicated impediments to health delivery.

Already, at the end of the second year, we are seeing some of the implications of this research. First, a number of agencies and schools are waiting for the data so that they can evaluate their services and modify them where needed. Second, our data on commitment indicate that new patterns are emerging; notably there has been a dramatic decline in admissions to state hospitals which, of necessity, will increase the community's responsibility for providing greater services. Third, we are now developing mental health screening measures in conjunction with the new Multiphasic Screening Center in Gainesville. About 500 of the respondents whom we interviewed are also receiving health examinations in that screening center. This work will provide validity and reliability checks on the symptom inventories in our interview schedule and will enable us to refine mental health screening measures for multiphasic centers located in the Southeast. Finally, we are cooperating with the staff of the new Community Mental Health Center in Eustis, Florida. A sample of 500 persons from that two-county catchment area is being interviewed in order to determine how that center can best meet the needs of those being served. Next year, we plan to present some results from that evaluation. The area served by the center at Eustis presents a number of contrasts with our own. For example, there is a much larger transitional population composed of both northern residents who winter in the area and of migrant laborers who are seasonally employed in the nearby citrus groves. In addition, there is a large concentration of older, retired, two-member families who have become permanent residents of the catchment area. The economy of the area is largely based on agriculture, citrus, and tourism in contrast to our north central Florida area. These differing sociocultural and demographic characteristics provide us with an invaluable reliability check on the utility of our interview schedule. If found to be reliable, different kinds of communities will be able to determine their needs and create assistance programs to meet those needs. Of special significance is the fact that this Eustis program, using a sample of 500 subjects, is being directed by local staff persons with a relatively small budget. We think this program can be the forerunner of others like it, as an increasing number of communities establish their own mental health care centers.

▶ Dr. Schwab, Department of Psychiatry, University of Florida College of Medicine, Gainesville 32601.

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Governor M. Witt, M.D.

Reprinted from The Bulletin, August, 1971, Palm Beach County Medical Society, Inc.

Occupational Medicine in Florida

Harold Baumgarten, M.D.

The most important aim of occupational medicine in Florida should be the health of the employee. Those responsible for maintaining the workers health and preventing accidents must include the worker himself, employer, insurance carrier, Florida Industrial Commission, and the occupational health physician.

The worker himself can obviously aid in maintaining his health by following the same basic rules that all people should follow, namely, eat a proper diet at regular intervals, get adequate sleep, enjoy hobbies and recreation time, and have periodic family physician checkups. On the job, the employer can provide a safe, clean and pleasant place to work in. Many large industrial employers have their own safety engineers and physicians to insure that the former provisions are made. They also employ fine personnel directors to solve any social problems or those arising due to a breakdown in communications among fellow employees or their supervisors. The smaller company directors must not shirk this responsibility but rather make every effort to create a safe, clean and pleasant work environment. The insurance carriers have an opportunity to play a greater role in promoting employee health. They can recommend preemployment examinations and safety standards at the plant and, of course, pay the medical costs incurred by on the job injuries or health problems. The Florida Industrial Commission along with the insurance carriers have the facilities to accumulate a great wealth of statistics as to what type of injury or health hazard occurs most frequently in each occupation. This type of data, especially when fed into a computer, can prove of immeasurable value in establishing minimum state standards for the plant environment, e.g., ventilation, lighting, sound level, temperature, toxic chemicals (substances), and the use of protective devices. The Florida Industrial Commission enforces the laws governing the carrying of workmen's compensation insurance by the employer, payment of just claims to the injured employees and their physicians, adjudication of injured employees claims against carriers, and advises the proper forms to be used and filed on time by the employers, physicians, and insurance carriers. Last, but not least, the occupational physician must provide an adequate facility to perform preemployment physicals, diagnose and treat medical industrial diseases and surgical industrial problems, provide for physiotherapy and rehabilitative treatments and make preventive medicine recommendations to employers.

I believe we could improve our industrial health program in Florida by:

1. Compulsory preemployment examinations with followup at regular intervals, e.g., two years.
2. Recognition awards or bonuses to employees with no lost time during the work year.
3. Punitive action against employees who knowingly attempt to have their personal health problems treated under workmen's compensation.
4. Punitive action against employers who discharge an employee because of lost time due to a bonafide on the job injury.
5. Rapid payment of bonafide claims by insurance carriers or the payment of interest on unpaid ones at regular prevailing banking rates.
6. Shorter and simpler compensation forms for workmen's compensation claims required of employers, physicians, and carriers by the Florida Industrial Commission.
7. Punitive action against employers who do not file an employer's report of injury with the insurance carrier within seven days after the date of injury of their employees.
8. Better lines of communications between employees (labor unions), employers, insurance carriers and occupational physicians to cooperate for an improved Florida industrial health program, e.g., combined meetings during each work year.
9. The payment of usual and customary fees to specialists who consult and treat industrial patients.
10. A greater dedication of the Florida occupational physician to the improvement of the health of our Florida workers.

Dr. Baumgarten, 761 North Edgewood Avenue, Jacksonville 32205.

Dr. Baumgarten is a member of the Committee on Environmental Medicine, Florida Academy of General Practice.

Drug Induced Dyskinesia Treated With Intravenous Diazepam

Roger G. Schnell, M.D.

Extrapyramidal symptoms of acute onset are a recognized side effect of prochlorperazine and other phenothiazine derivates.[1-8] Although not life threatening, dislocations of the jaw have occurred, and the symptoms of respiratory distress, laryngeal and pharyngeal muscle spasm, have lead to tracheotomy and endotrachial intubation. Therefore, prompt diagnosis and treatment may be important.

Many drugs including barbituates (sodium phenobarbital), antihistamines (diphenhydramine chloride, promethazine), caffeine, meperidine, methodarbamol, antiparkinson medications (benzotropine-mesylate, biperiden) and others have been used to alleviate the extrapyramidal symptoms. The speed of recovery following treatment has varied from five minutes to many hours. This case report demonstrates a mode of treatment that lead to immediate relief.

Report of Case

The 15-year-old white female school girl had sudden onset of abdominal cramps, anorexia, vomiting, malaise with temperature elevation. Because of inability to retain fluids over a three-day period, she was hospitalized. The patient received 3,000 cc. of intravenous fluids in the ensuing 36-hour period. Heterophile antibody titer, stool and urine cultures, chest x-ray, serum bilirubin and alkaline phosphatase were all normal. The white blood cell count was 8,400 with differential of 77 segmented neutrophils, 2 stabforms, 17 lymphocytes, 3 monocytes and 1 eosinophil. She was discharged on prochlorperazine 15 mg. spansules on 11/24/68.

Over the ensuing 48 hours the patient took six 15 mg. prochlorperazine spansules, the last at 1 p.m. on 11/26/68. Approximately 30 minutes later, she noted her neck pulling back, abnormal extension of digits of the hands, with writhing movement of hands and arms. Although aware of these abnormal movements she stated, "I was unable to do anything about them." In addition, her tongue felt "thick" and speech was slurred. Her jaw began to deviate to the left, and she could not open her mouth fully. The patient was then brought to the hospital emergency room.

Examination revealed a 15-year-old apprehensive white female with facial grimacing, opisthotonos, trismus, jaw protrusion to the left, writhing distonic movements of the upper extremities. She was mentally alert and appropriate. Speech was dysarthric, and rapid movements of the tongue were impossible. Hands were extended, with fingers spread. There was adduction of the right leg in spasmotic sequences, bilateral ankle clonus, extensor toe signs, and hyperactive reflexes. Neurologic examination was otherwise negative. A cerebrospinal fluid examination was normal. The patient received 5 mg. diazapam IV and within 30 seconds the opisthotonos stopped, dyskinesia and trismus disappeared and neck discomfort abated.

There was no detectable effect on respiration, blood pressure or pulse following the injection of diazepam. An Abbott #21 intercath was inserted, and two hours later the patient noted recurrence of symptoms in milder degree and received a second injection of 5 mg. diazepam. Again there was immediate relief. The patient did well and was discharged 24 hours later without symptoms.

Discussion

Neuromuscular symptoms occur in from 0.7% to 15% of patients on phenothiazine derivatives.[6,7] In many cases they have occurred in the nonpsychiatric population when these drugs were used in the management of vomiting. It is possible that dehydration may be a contributing factor to the extrapyramidal side effects. Significantly, in many cases these manifestations were not the result of overdose but appeared to have a specific neuroleptic effect in susceptible individuals.

The acute onset of the dyskinetic syndrome is dramatic and alarming to the patient and physician. If a history of drug intake is not immediately available, the differential considerations including meningitis, encephalitis, tetany, catatonic schizophrenia, strychnine poisoning, tetanus, atypical epilepsy and rabies, have dire implications. In addition, the dyskinesia itself may lead to unnecessary procedures and emotional distress. The immediate treatment with diazepam is, therefore, recommended for rapid relief of drug induced dyskinesia.

Summary

Diazepam in doses of 5 mg. administered intravenously was found to relieve prochlorperazine induced dyskinesia in a 15-year-old girl. Because of the prompt effect, lack of side effects and ease of administration, diazepam may deserve a place in the treatment of drug induced dyskinesias.

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Dr. Schnell, 4800 Northeast 20th Terrace, Fort Lauderdale 33308.

I find the great thing in this world is not so much where we stand, as in what direction we are moving . . .

We must sail sometimes with the wind and sometimes against it . . .

But we must sail and not drift, nor lie at anchor.

Oliver Wendell Holmes

Endocrinopathies and Arthropathies

Louis M. Sales, M.D.

The advent of the corticosteroids and their use in rheumatoid arthritis gave marked impetus to the study of endocrinological disturbances in rheumatoid arthritis and associated collagen diseases. Considerable hope was stimulated, at first, that studies might find an answer to the etiology and the cure of many of these autoimmune disorders. Unfortunately this did not prove to be the case and, in fact, no specific endocrinopathy has been established up to this time as causative in any of these diseases. Nevertheless, sufficient interest has been generated to warrant a short review article detailing some of the endocrinological disturbances in some of the arthridities; specific arthropathies seen in certain endocrinopathies and the concomitant occurrence of both endocrinological and arthritic disorders in various generalized systemic diseases.

Endocrinological Disturbances in Rheumatoid Arthritis and the Collagen Diseases

Experimental evidence to date indicates that endocrine factors may play a conditioning role but not a direct etiological one in this group of diseases. Polyarthritis has been produced in rats following prolonged treatment with anterior pituitary extract. Other workers have seen improvement in subjects with rheumatoid arthritis in whom calf and hog anterior pituitary glands have been implanted. Similarly, growth hormone has produced changes suggesting hypertrophic polyarthritis in rats, as well as stimulating fibroblastic proliferation in these animals. Collagen formation may be stimulated by the simultaneous administration of thyrotropin and growth hormone and thyrotropin itself increases the amount of intercellular mucopolysaccharide material including hyaluronic acid. Prolactin plays an even greater role than does growth hormone in producing polyarthritis in the adrenalectomized or hypophysectomized rat.

The mineralocorticoids, in general, stimulate the formation of foreign body granulomata, proliferation and activity of fibroblasts in connective tissue, and the formation of granulation tissue. Experimental arthritis and cardiovascular lesions have occasionally been produced in rats by these substances. The glucocorticoids, on the contrary, inhibit the growth and migration of fibroblasts, the fibroblastic production of collagen, the intercellular contents of mucopolysaccharide and hexosamine and the relative amount of intercellular ground substance.

Studies on man have produced no general agreement as to whether adrenal cortical function is normal, decreased or increased in patients with rheumatoid arthritis.

Thyroid hormones decrease mucopolysaccharides, hyaluronic acid and hexosamine and ground substance, as well as the formation of collagen fibers in growing connective tissue. However, there is no overt clinical relationship between hyper or hypothyroidism and the rheumatic disease states. While rheumatoid arthritis can occur in both, it is somewhat more common in patients with hypothyroidism. Moreover, the vague muscular and articular pains which occur in myxedema can be masked as arthritis, but the pain of hypothyroidism is usually associated with stiffness and coldness and is diffuse in location and more generally confused with fibrositis than with rheumatoid arthritis. Of interest is the fact that following thyroidectomy in patients with rheumatoid arthritis, a large percentage have a clinical exacerbation of the arthritis. Finally, it is shown that hypertrophic pulmonary osteoarthropathy may develop in patients with postoperative myxedema.

While decreases in both estrogens and androgens have been shown to significantly enhance the development of osteoporosis, there is no clear-cut clinical relationship between the level of these hormones and the development of rheumatic diseases. There is some evidence that estrogen increases connective tissue mucopolysaccharide and hyaluronic acid while progesterone seems to counteract these effects. Testosterone affects connective tissue only in animals in which there is a

Dr. Sales is co-chief of the Arthritis and Collagen Disease Clinics of Duval Medical Center and Baptist Memorial Hospital, Jacksonville.

deficiency of the hormone. Numerous attempts at therapy with all of these agents have been unsuccessful in rheumatoid arthritis.

Rheumatoid arthritis has been seen in both hyper and hypoparathyroidism, although occasionally the bone lesions of hyperparathyroidism may cause bone pain and arthralgias similar to those of arthritis. There is no evidence to indicate that the prostate or any other gland is involved in ankylosing spondylitis.

Tumors of the parotid gland, of the pancreas, and chromaphobe adenomas of the pituitary have all been reported in dermatomyositis. No specific endocrinological abnormality per se has been described as yet in either disseminated lupus, polyarteritis nodosa, or scleroderma, although Hashimoto's thyroiditis has been reported as more common in both D.L.E. and scleroderma.

Arthropathies in Primary Endocrine Diseases

Osteomalacia may be due to inadequate calcium and occasionally phosphorus intake, either due to dietary lack alone or relative dietary insufficiency during rapid bone growth, pregnancy, hyperthyroidism and malabsorption syndrome. Osteomalacia may also be due to inadequate dietary vitamin D intake, malabsorption, vitamin D resistant rickets, or congenital or acquired renal defects including phosphate diabetes, Fanconi-type syndromes, azotemic osteodystrophy, and the acquired Fanconi syndrome (either Wilson's disease or the ingestion of outdated tetracyclines.)

Hyperparathyroidism, whether primary or secondary, may produce a picture of osteitis fibrosa cystica generalisata and occasionally may be linked with this disorder.

In acromegaly, arthritic manifestations are not unusual and widespread osteoarthritic-like changes of bone and joints are often demonstrable.

Generalized Systemic Diseases Manifesting Both Endocrinopathy and Arthropathy

Included in this group must be any generalized systemic diseases which may involve both articular surfaces and endocrine organs. Specifically considered here is tuberculosis with fairly characteristic bone and joint involvement and with involvement, in some cases, of various endocrine organs. Most commonly implicated is the genitourinary tract with resultant ovarian and testicular dysfunction and, in some instances, menstrual irregularity and even affections of secondary sex characteristics. In days gone by, adrenal insufficiency was a more common concomitant of this disease. An intracranial tuberculoma properly placed may produce disturbances of the hypothalamus or the pituitary. Thyroiditis is an extremely rare occurrence.

In sarcoidosis, arthritis may be an initial manifestation for years before other symptoms become clear or may occur several years after the onset of the disease, with multiple peripheral joint involvement, either acute, recurrent or chronic, of variable duration and frequency of attacks and not infrequently with erythema nodosum accompanying the arthritis.

Syphilis frequently affects joints and, in addition, particularly through gumma formation, will affect almost any endocrine organ in the body. This is a much less frequent problem now than in the prepenicillin era.

Similarly, a host of other infectious diseases, when involvement is widespread enough, may produce both arthritic and endocrinological abnormalities.

Summary

A brief review is presented of some of the endocrinological abnormalities seen in the so-called collagen disorders, specific arthropathies seen in some endocrinopathies and the concomitant occurrence of both endocrinological and arthritic disorders in various generalized systemic diseases.

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Dr. Sales, 1204 LeBaron Avenue, Jacksonville 32207.

So long as I was a victim of my past I could only rebel against it or accept it and resent those who imposed it upon me. However, as a responsible agent I am free to sift the values, attitudes and models which are my legacy from the past and to reject those which are alien to my present experience and affirm those which are compatible.

Quote from To a Dancing God by Sam Keen

The Florida Cardiovascular Screening Program

M. E. Groover Jr., M.D., J. E. Fulghum, M.D., and W. W. Mahoney, M.P.H.

A cardiovascular screening program was presented to the Florida Medical Association in 1967 by the Heart Disease Control Program, Bureau of Adult Health and Chronic Disease, of the old state Board of Health. The program was approved by the Florida Society of Pathologists and the Florida Medical Association with the suggestion that it be tried in one area initially and expanded to other areas only with the cooperation of the concerned county medical societies.

This is a report of the first 1,000 people screened and followed-up. The central objective of the program is to identify high risk people who are more likely to develop the acute clinical manifestations of atherosclerosis, and to refer them to the physician of their choice with enough data to enable the physician to justify a diagnostic work-up and to start prophylactic treatment if indicated.

The two-county health unit consisting of Nassau and Baker Counties was chosen for the pilot study because of its proximity to the central office of the Division of Health in Jacksonville, the county medical society felt the need for such a program, the county health officer was anxious to develop a program to attack cardiovascular disease which he considered his most important public health problem, and a group of militant and dedicated young women was available to take over the program as their community service project and staff the screening center with high quality nonpaid workers.

Method

The program was operated without additional funds. No money was available for employing personnel; however, some supplies and an electrocardiograph were purchased from funds in the budget of the Bureau of Adult Health and Chronic Diseases in the Florida Division of Health. Facilities already existed in the central laboratory for analyzing the blood samples.

The Jaycee Wives Club adopted the program in Nassau County. These women were given an intensive training course. They were taught to take the medical history and record the data indicated on the screening form (Fig. 1). Nurses among them were taught to draw blood for the lipid profile indicated on the laboratory form (Fig. 2.) and to make electrocardiograph tracings. Others were taught to compile information on the physicians referral letter (Fig. 3), the reverse side of which contains the referral criteria shown in Figure 4.

The laboratory tests were completed in the central laboratory of the Division of Health in Jacksonville. This laboratory operates under the surveillance of the National Communicable Disease Center in Atlanta, the accuracy of which is accepted as the standard for these procedures in this program.

After completion of the training program a health education program was launched to inform the population about risk factors, heart disease and stroke.

The risk factors include (1) A family history of heart disease and stroke in parents under 60 years of age, (2) High blood pressure in mother or father, (3) Personal history of heart attack, stroke or T.I.A., (4) Personal history of angina pectoris, (5) Personal history of hypertension with active treatment, (6) An abnormal EKG, (7) History of diabetes, (8) Blood sugar above 110 mg.% fasting or above 135 mg.% 2 hours postprandial, (9) Blood cholesterol above 250 mg.%, and (10) Blood triglyceride above 200 mg.%.

In addition to training in the operation of the screening center, a small group of volunteer workers were taught to obtain the information at the

Dr. Groover is administrator of the Heart Disease Control Section, Bureau of Adult Health and Chronic Disease, Florida Division of Health. Dr. Fulghum is chief of the Bureau and Mr. Mahoney is health program specialist, Heart Disease Control Section. This is a report to the Florida Medical Association.

STATE OF FLORIDA

DEPARTMENT of HEALTH and REHABILITATIVE SERVICES
DIVISION OF HEALTH
CARDIOVASCULAR SCREENING CENTER
_____, FLORIDA

Form No. 1

NAME _____ PHONE _____

ADDRESS _____

PHYSICIAN _____

- [] [] [] [] [] [] – – – – – Date (Month-Day-Year)
- [] [] [] – – – – – – – – – Center Number
- [] [] [] [] [] [] – – Person Number
- [] [] [] [] [] [] [] [] – – Soc. Sec. Number
- [] [] – – – – – – – – – Age in Years
- [] – – – – – – – – – – Sex
- [] – – – – – – – – – – Ethnic Origin
- [] [] – – – – – – – – – Height
- [] [] – – – – – – – – – Weight
- [] – – – – – – – – – – Marital Status
- [] [] [] [] [] [] – – – – – Blood Pressure
- [] [] – – – – – – – – – Pulse
- [] [] – – – – – – – – – EKG
- [] – – – – – – – – – – Chest X-Ray

Sex	Ethnic Origin	Marital Status	EKG
0-Unk.	0-Unk.	0-Unk.	0-Not Done
1-Male	1-Negro	1-Single	1-Normal
2-Female	2-Am. Ind.	2-Married	2-LAD
	3-Hebrew	3-Widowed	3-LVH
X-Ray	4-Mediterr.	4-Divorced	4-ST, T changes
	5-Lat. Am.		5-PVC
0-Not Done	6-N. Eur.		6-LAD, LVH
1-Normal	7-Oriental		7-LAD, LVH, ST and T changes
2-Abnormal	8-Cuban		8-LAD, LVH, ST and T changes, PVC
	9-Other		9 -LAD, PVC
			10 -LVH, PVC
			11 -LVH, ST and T changes
			12 -RT. BBB
			13 -LF. BBB
			14 -Aur. Fibrltn.
			15 -Other abnormalities

FAMILY HISTORY

- [] – – – Angina Pectoris
- [] – – – Heart Disease
- [] – – – Hypertension
- [] – – – Stroke
- [] – – – Gout
- [] – – – Diabetes
- [] – – – Emphysema

0-Unk. 1-No 2-Pat. 3-Mat. 4-Both 5-Sibs 6-2&5 7-3&5 8-All

COMMENTS: Diet, etc.

PERSONAL HISTORY

- [] – – – Angina Pectoris
- [] – – – Heart Disease
- [] – – – Hypertension
- [] – – – Stroke
- [] – – – Gout
- [] – – – Diabetes
- [] – – – Emphysema
- [] – – – Rx for Blood Pressure
- [] – – – Digitalis Medication
- [] – – – Nitroglycerin Medication
- [] – – – Physical Activity
- [] [] – – Smoking

0-Unk. 1-No 2-Yes, now 3-Yes, remote 4-Yes, Rx

Physical Activity	Smoking	
0-Unk.	0-Unk.	4-Yes, cigars
1-Sedentary	1-No, never	5-Yes, 2&3
2-Moderate	2-Yes, cigts.	6-Yes, 3&4
3-Active	3-Yes, pipe	7-Yes, 2&4
		8-Yes, 2&3&4
		9-Quit, 1 year
		10-Quit, 1 year+

LAB RESULTS

- [] [] [] – – – Blood Sugar – mg%
- [] [] [] – – – Blood Cholesterol – mg%
- [] [] [] – – – Blood Uric Acid – mg%
- [] [] [] – – – Triglycerides – mg%
- [] [] [] – – – Beta Lipoprotein Mobility – mm.
- [] [] [] – – – Beta-1 Lipoprotein – %
- [] [] [] – – – Beta-2 Lipoprotein – %
- [] [] [] – – – Beta-3 Lipoprotein – %
- [] [] [] – – – Hemoglobin – Gms.
- [] – – – – – Pap Smear
- [] [] [] [] [] – Urinalysis

B P G K pH

Pap Smear: 0-Not Done 1-Normal 2-Abnormal

Date _____
Permission granted to perform screening tests and send report to my physician.

Screenee _____

Witness _____

URINALYSIS

0-Unk. 1-Positive 2-Negative

pH: 0-Unk. 1-5 2-6 3-7 4-8 5-9

- [] – Referred
- [] – Complied
- [] – Treated
- [] – Not Treated

FOLLOW-UP (12 months)

- [] – Remaining under Rx
- [] – Living (No Rx)
- [] – Deceased – Vascular Disease
- [] – Deceased – Cancer
- [] – Deceased – Other

0-Unk. 1-No 2-Yes

Figure 1.

State of Florida • Department of Health and Rehabilitative Services • Division of Health

LABORATORY

(Send this sheet to the laboratory with blood specimens)

Name:_____ Patient No._____ County No._____ Date_____

Address_____

Date_____

Blood Drawn _____ AM _____ PM

_____ Center Number

Last Meal _____ AM _____ PM

_____ Person Number

Meal Content: _____

_____ Person's Social Security No.

Name_____ Age_____

Blood Sugar	mg%
Blood Cholesterol	mg%
Blood Uric Acid	mg%
Triglycerides	mg%
Beta Lipoprotein mobility	mobility
Beta (1) Lipoprotein	%
Beta (2) Lipoprotein	%
Beta (3) Lipoprotein	%
Hemoglobin	Gms.
BUN	mg%

_____ _____

County Health Department Health Officer's Signature

BLOOD TESTS LISTED ABOVE REQUIRE THREE (3) VACUTAINER TUBES, 1 RED TOP, 1 LAVENDER TOP, AND 1 GRAY TOP.

Send to: State of Florida
DIVISION OF HEALTH
Bureau of Laboratories
P. O. Box 210
Jacksonville, Florida 32201

Figure 2.

bottom of the coded screening form (Fig. 1). This follow-up occurred 12 months after the screening; it determined if the person was living and whether he was still under treatment. The procedure is necessary to evaluate the program.

All of the people presenting themselves at screening centers did so as a result of the health education program directed to the population through radio, the press and personal contact with local civic organizations, schools and churches. Most of those who volunteered to be screened had something to spark their interest in the program such as vague symptoms or a positive family history of heart disease. For this reason, the number of cases found was much higher than would be expected if healthy employees of an industrial organization were screened as a captive population.

Results

Of the 1,000 persons screened, 429 were referred to physicians. Two died before they could make an appointment with a physician. Both had abnormal EKG tracings and hypertriglyceridemia, one had unsuspected diabetes and the other had hypertension—blood pressure 222/142.

Among those referred, there were 34 cases of previously undiagnosed diabetes; 72 cases with blood cholesterol above 300 mg.% and 59 with triglycerides above 250 mg.%; 199 EKG tracings indicating old myocardial infarcts; 127 cases of previously undiagnosed arterial hypertension and 36 of known hypertension that had never been treated; 66 cases of severe hypertension that had been treated but treatment had been discontinued because the patients thought they were cured. It is interesting that 56% of those who had a stroke never knew they had hypertension until they were examined after the stroke.

The economic status of the screenees was estimated as; high 12%, middle 84% and low 4%. An effort was made to interview a number of persons from the lower economic class to determine why they did not avail themselves of the service. They revealed the fact that the screening center did nothing but tell them to see a doctor. If they had enough money, they would do that anyway.

Since the screening centers are operated mainly by young housewives who have families to care for, and since the screening activity is in the county health department facilities during the normal 8:00 a.m. to 5:00 p.m. working hours, it was not surprising that only 36.5% of the screenees were males between 20 and 50 years of age. The screening center was not available after regular working hours.

The family history seemed to be the greatest single factor attracting people to the screening center. Fifty-one percent of the entire group and 72.3% of the males had a family history of heart disease, stroke or severe hypertension. People were not referred to their physician for hypertension and family history without some other abnormality. When the data is completely analyzed and presented to county medical societies this referral criteria may be changed.

Screenee Compliance

At the six month follow-up of the 429 persons referred, 101 were already seeing their physician for unrelated conditions and 228 made appointments as advised. Eighty-one saw doctors one time but did not return for follow-up visits; they stated they were still following the physician's instructions. Nineteen said they thought it unnecessary and discontinued prophylactic treatment and resumed cigarette smoking.

At the end of 12 months, 305 were still under treatment, 70 were living but not taking treatment, 41 were lost to follow-up, three died of vascular disease, two died of cancer and one in an auto accident.

Physician Acceptance

The screening program has been the most popular of all health department activities with the practicing physicians. They feel that the information sent in the referral letter is adequate to justify putting the patient to the expense of a diagnostic study, and in many cases they have been able to start the patient on a prophylactic treatment program with a minimum of extra expense. The program has identified high risk people occasionally among their own patients. One physician said that he did not routinely screen his patients for cardiovascular disease unless specifically requested to do so. He was willing to do the necessary repeat blood tests once the patient had been identified as being in the high risk category.

Discussion

The concept of the prevention of cardiovascular disease has gone through a series of changes during the past 30 years, from considering strokes and heart attacks to be an act of God to a period of heated controversy, and now to a time when

STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES
DIVISION OF HEALTH
CARDIOVASCULAR SCREENING CENTER

_____, Florida

Date _____

TO: _____, M.D.

_____ was tested in the cardiovascular screening center _____, 19__ and requested the test results be sent to you. Listed below is pertinent information which may be of aid to you in your evaluation of the screenee.

Physical Data:	Blood Analysis:	Misc. Tests:
Age _____	Blood Sugar _____ mg%	X-Ray _____
Height _____	Blood Cholesterol _____ mg%	Pap Smear _____
Weight _____	Blood Uric Acid _____ mg%	Urinalysis: _____
Sex _____	Triglycerides _____ mg%	_____ - pH
Pulse Rate _____	Beta Lipoprotein Mobility _____ mm.	_____ - Protein
Systolic BP _____	Beta - 1 Lipoprotein _____ %	_____ - Glucose
Diastolic BP _____	Beta - 2 Lipoprotein _____ %	_____ - Ketones
Ethnic Origin _____	Beta - 3 Lipoprotein _____ %	_____ -Blood
REMARKS (As given by screenee)	Hemoglobin _____ Gms.	Other _____

Family History _____

Personal History and Present State of Health _____

Physical Activity _____

Smoking History _____

Medication _____

Diet _____

Other _____

EKG: Full Report is Attached.

Director, County Health Department

[] This is a routine report to private physician.

[] Screenee has been referred to you.

Figure 3.

FLORIDA CARDIOVASCULAR SCREENING PROGRAM
SUGGESTED REFERRAL CRITERIA

SCREENING PROCEDURE	DETECTION PURPOSE	ELIGIBILITY (age)	SUGGESTED REFERRAL LEVEL
1. History	Identify Disease	All Ages	Abnormal if not under care
2. Obesity	Risk Factor	All Ages	25% over weight
3. Pulse	Arrhythmia	All Ages	Any arrhythmia
4. Blood Pressure	Arterial Hyper.	All Ages	BP greater than 150/90
5. EKG	Identify Disease	All Ages	Any abnormality
6. Sugar	Risk Factor	All Ages	Fast 110 / 1 hr. 160 / 2 hr. 120 / 3 hr. 110
7. Uric Acid	Coronary risk Gout	All Ages	6 mg% and above
8. Cholesterol	Coronary risk	All Ages	250 mg%
9. Triglycerides	Coronary risk	All Ages	200 mg%
10. Beta Lipoprotein mobility(blood)	Coronary risk	All Ages	None (less 10%)
11. Beta (1) LP	Coronary risk	All Ages	10% or more
12. Beta (2) LP	Coronary risk	All Ages	85% and above } If Fasting
13. Beta (3) LP	Coronary risk	All Ages	All positive
14. Hemoglobin	Anemia Polycythemia Coronary risk	All Ages	Above 17 gm. Below 10 gm.
15. Sugar(urine)	Diabetes	All Ages	All positive
16. Protein(urine)	Nephrosis Nephritis	All Ages	All positive
17. pH(urine)	Acidosis Alkylosis	All Ages	All positive
18. Occult blood	Nephritis	All Ages	All positive
19. Ketones(urine)	Diabetes	All Ages	All positive

Figure 4

the majority of physicians appear to consider prophylactic treatment of considerable value. Epidemiological studies in Massachusetts,[1] Michigan[2] and Minnesota[3] have presented evidence to show that the relationship between hypertension and hyperlipidemia to cardiovascular disease is a real one.

For example, men 30 to 50 years of age with systolic blood pressure between 120 and 140 mm. Hg. have a statistical probability of developing a myocardial infarction 3.8 times that of similar age men of the same age group with systolic blood pressure of 120 mm. Hg. or lower. They have also shown that men of the same age group with blood cholesterol 240 mg.% and above have a risk of developing coronary heart disease 2.6 times greater than those with blood cholesterol of 200 mg.% or lower.

In addition to these data, the statistical evidence for an important casual relationship between cigarette smoking and both coronary heart disease and chronic lung disease has never been refuted.[4] The elimination of cigarette smoking is one risk factor physicians can recommend without fear of serious side effects.

The statistical association of hyperlipidemia with increased coronary heart disease does not necessarily prove a causal relationship. However, a large body of independent evidence based on animal experiments leaves no doubt as to the causal role of hypercholesterolemia in the experimental induction of atherosclerosis in practically every species studied.[5-7] Furthermore, the regression of atherosclerotic lesions in animals occurs when hypercholesterolemia is brought under control.[8]

Even the most skeptical of us attempt to keep our postmyocardial infarction patients on a prophylactic treatment program once they have recovered from the acute attack. The question most patients ask is, "Doctor if this is so important, why didn't you treat me before I had the first attack?"

Physicians know that 25% to 40% of patients with myocardial infarction never live long enough to reach medical attention and, if prophylactic treatment is of any value, some means of identifying high risk patients and getting them in the hands of their physician must be provided before the first acute attack.

This cardiovascular screening program is designed to identify the high risk person and to present the patient to his physician with enough supporting data to justify the time and effort required to prescribe a prophylactic treatment program tailored to the individuals needs.

The Division of Health through the Bureau of Adult Health and Chronic Disease can assist any county medical society in establishing a cardiovascular screening program if this seems to fit the needs of the community. The program is administered through the director of the county health department with the cooperation and guidance of the county medical society. Blood tests for the lipid profile are done in the central laboratory. EKG tracings are interpreted by a computer either in Gainesville or in Tampa and reviewed by an internist in the Division of Health.

All personnel for staffing the screening center are recruited from especially selected local volunteers and trained by Division of Health employees. The Florida Regional Medical Program has purchased supplies, some equipment and provides funds for the computer interpretation of EKG tracings.

The pilot project was started three years ago. To date, county medical societies have adopted the plan in 17 counties. The program has been implemented on a limited scale in six other counties.

Summary

If physicians are to have the opportunity of treating patients to prevent acute heart attacks or strokes, the patient must be identified and referred to the physician with enough supporting evidence to justify his doing the necessary diagnostic study and prescribing an individually tailored prophylactic treatment program.

Report of Screening of Florida physicians at 1970-1971 annual meetings will be published in a later issue.

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▶ Dr. Groover, P.O. Box 210, Jacksonville 32201.

Bland Diet in the Treatment Of Chronic Duodenal Ulcer Disease

The bland diet and its modifications have been used for many years as part of the treatment for duodenal ulcer and other gastrointestinal disorders. It has most often been defined as one which is chemically and mechanically nonirritating;[1,2] however, there is considerable lack of agreement as to which foods are actually nonirritating. Review of diet manuals from many states reveal regional differences as to foods allowed.[3] In reviewing the literature, it is noted that much of the rationale for the bland diet is based on tradition and folklore.[3-8]

The American Dietetic Association, in its commitment to interpret and apply the science of nutrition in the promotion of individual, group, and community health:

I. Recognizes that the rationale (chemically and mechanically nonirritating) for the bland diet is not sufficiently supported by scientific evidence.
 A. Spices, condiments, and highly seasoned foods are usually omitted on the basis that they irritate the gastric mucosa; however, experiments have indicated that no significant irritation occurs, even when most condiments are applied directly on the gastric mucosa.[1-3] Exceptions are those items which do cause gastric irritation, including black pepper, chili powder, caffeine, coffee, tea, cocoa, alcohol, and drugs.[2,3,6,9]
 B. Milk has been the basis of diets for duodenal ulcer for many years. One of the primary aims in dietary management of duodenal ulcer disease is to reduce acid secretion and neutralize the acid present.[8] While milk does relieve duodenal ulcer pain, the acid neutralizing effect is slight.[1,7,10] Its buffering action could be outweighed by its ability to stimulate acid production.[10] Most foods stimulate acid secretion to some extent; protein provides the greatest buffering action and is also the most powerful stimulus to acid secretion.[3,5,7,11-13] The use of milk therapy has been greatly reduced over the past decade, owing to a better knowledge of its side effects and allergic reactions.[1,7,10,14] The controversy regarding the use of milk still continues. There are those who still advocate the regular use of milk,[2,5] primarily during the active stage of acute duodenal ulcer; however, strict insistence on its use during remission is unwarranted.[7,10,14,15]
 C. Roughage, or coarse food, has been excluded from the diet on the basis that it aggravates the inflamed mucosal area. There is no evidence that such foods as fruit skins, lettuce, nuts, and celery, when they are well masticated and mixed with saliva, will scrape or irritate the duodenal ulcer.[12,14] Grinding or puréeing of foods is necessary only when the teeth are in poor condition or missing.
 D. The effect of a bland diet on the healing of duodenal ulcer has been studied extensively. Investigations have compared various bland diets with regular or free-choice diets.[1,3,8,16-17] The results indicate that a bland diet made no significant difference in healing the ulcer. One such study[8] demonstrated that the acidity of the gastric contents was frequently lower when a free-choice diet was taken. Many foods have been incriminated as the cause of gastric discomfort and are subsequently eliminated from a patient's diet. Studies done on patients with and without documented gastrointestinal disease indicate that those with gastrointestinal disease cannot be distinguished by food intolerance.[14] Symptoms of intolerance were more related to individual response than to intake of specific food or the presence of disease.

II. Believes that scientific investigation supports the validity of frequent, small feedings in the management of patients with duodenal ulcer disease.[8] These have been found to offer the most comfort to the patient;[6] additionally,

*Position Paper of the American Dietetic Association. Approved by the Executive Board, American Dietetic Association, May 21, 1971, and reprinted from September 1971 issue of Journal of the American Dietetic Association.

acidity of the gastric contents is lower with small-volume, frequent feedings. It must also be recognized that rest, preferably in bed, rapidly reduces duodenal ulcer symptoms.[5,7,15] This is a specially important factor in the healing of the ulcer.

III. Believes the following points should be of major consideration in developing a dietary plan for duodenal ulcer patients.
 A. Individualization of the dietary plan, since patients differ as to specific food intolerances, living patterns, life styles, work hours, and education.
 B. Utilization of small volume, frequent feedings.
 C. Provision of educational materials relative to dietary support.

IV. Advocates the continued pursuit of current research and recommends that valid information be utilized in up-dating dietary regimens.

V. Suggests that dietetic practitioners be cognizant of the possible harmful effects of a milk-rich bland diet in patients who have a tendency towards hypercalcemia and/or atherosclerosis.

References are available upon request.

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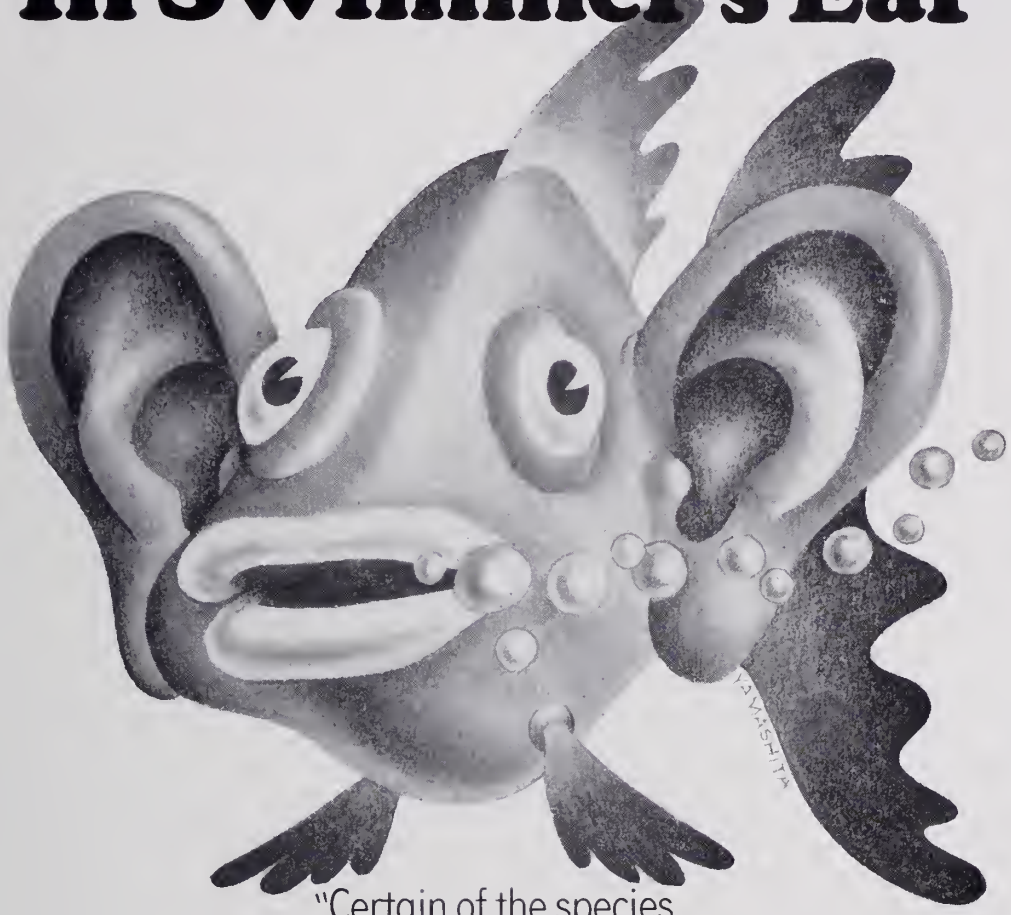
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Editorials

A Clean Slate

Doest thou love life, then do not squander time,
for that is the stuff life is made of.

BEN FRANKLIN

Once again there stands before me, a brand new year with 365 days, plus an extra one for good measure, to forget superstitions, defeats, fears and to find time to talk sense to myself. Living neither in the past nor in the future, let me, every day, plan my work and set my goals, and do that day's work superbly well, and I will find something to enjoy and much to do. Let me remember that I can succeed in future undertakings as I have done in the past, that I can correct mistakes and rise above failures, that each new day is a new lifetime with the opportunity to start once again to reach for a new goal. Let me not enslave my thinking with self-critical abuse, blocking off my feelings with walls of inhibitions but as my own plastic surgeon, bloodlessly and compassionately, I can cut away self-hatred to improve my self-image, thus, needing not to retreat from life or self respect. Help me to remember that one's pacemaker in creative living is my belief in myself, which gives expansive hope for happiness.

May I live this year creatively, building a feeling of strength, but budgeting my strength to attain short and long term goals. Let me not place my faith in material things nor make worldly success the end and aim of my existence but let me remember the worth of service to my family, my patients and my country.

Confronted by the limitless demands of the new year, I would enter it with humility and concern, forgetting the lust of vain desires that would ensnare me, the sweetness of revenge that could seduce me, wrath that makes me irreconcilable, and the coldness of heart when I lack consideration for those less fortunate than myself. Neither will I enter the new year empty handed, for with me I will take the memory of fearful doubts set at rest, the faithful friendship of some around me, and the self satisfaction of accomplishments of the past.

Since life is measured by thought and action, not time, neither is a man's value measured by the years he has lived or the work he has done but by the character he has molded. A man lives by believing in something, not by debating and arguing about many things and so each day, may I learn and live and "lead my life and practice my art in uprightness and honor."

C.M.C.

New Classification of Drugs

Prescription labeling and promotional material on most currently prescribed drugs will soon display a rating of the drugs efficacy for certain of the claimed indications.

The action is being taken by the Food and Drug Administration in the belief that the prescribing physician should know the scientific status of a given drug's efficacy in order to exercise the best possible clinical judgment in choosing drugs for patients, and is based on reports from the National Academy of Sciences' Drug Efficacy Study. This program stems directly from requirements of the Federal Food, Drug and Cosmetic Act enacted in 1938, requiring preclearance of new drugs for safety.

The Drug Amendment of 1962 (Kefauver-Harris) required that effectiveness as well as safety of drugs be established prior to marketing; therefore, since 1962, the FDA has reviewed all new drug applications for both safety and effectiveness. But the 1962 amendments also required that all drugs marketed between 1938 and 1962 and tested only for safety, now be evaluated for effectiveness as well. To accomplish this within a reasonable time, the FDA asked for assistance from the National Academy of Science who assembled 30 panels with some 200 medical and scientific specialists, "predominately physicians with academic affiliations." This group considered information gathered from all sources including FDA files and other scientific literature and on the basis of this information, was able to make informed judgments classifying more than 4,000 drug formulations into the following categories:

EFFECTIVE: Substantial evidence of effectiveness.

PROBABLY EFFECTIVE: Additional evidence required to rate the drug "effective."

POSSIBLY EFFECTIVE: While additional evidence for an "effective" rating might be forthcoming, as it stands there is little evidence of effectiveness, and in the absence of substantial evidence, the claim is considered inappropriate.

INEFFECTIVE: Lack of substantial evidence of efficacy.

INEFFECTIVE AS A FIXED COMBINATION: Even though one or more of the components might be effective if used alone, not acceptable in fixed dosage combination for reasons of safety or because of lack of evidence of contribution of each component to claimed effect.

EFFECTIVE BUT: With an appropriate qualification. This difficult group is under reconsideration by NAS/NRC and FDA.

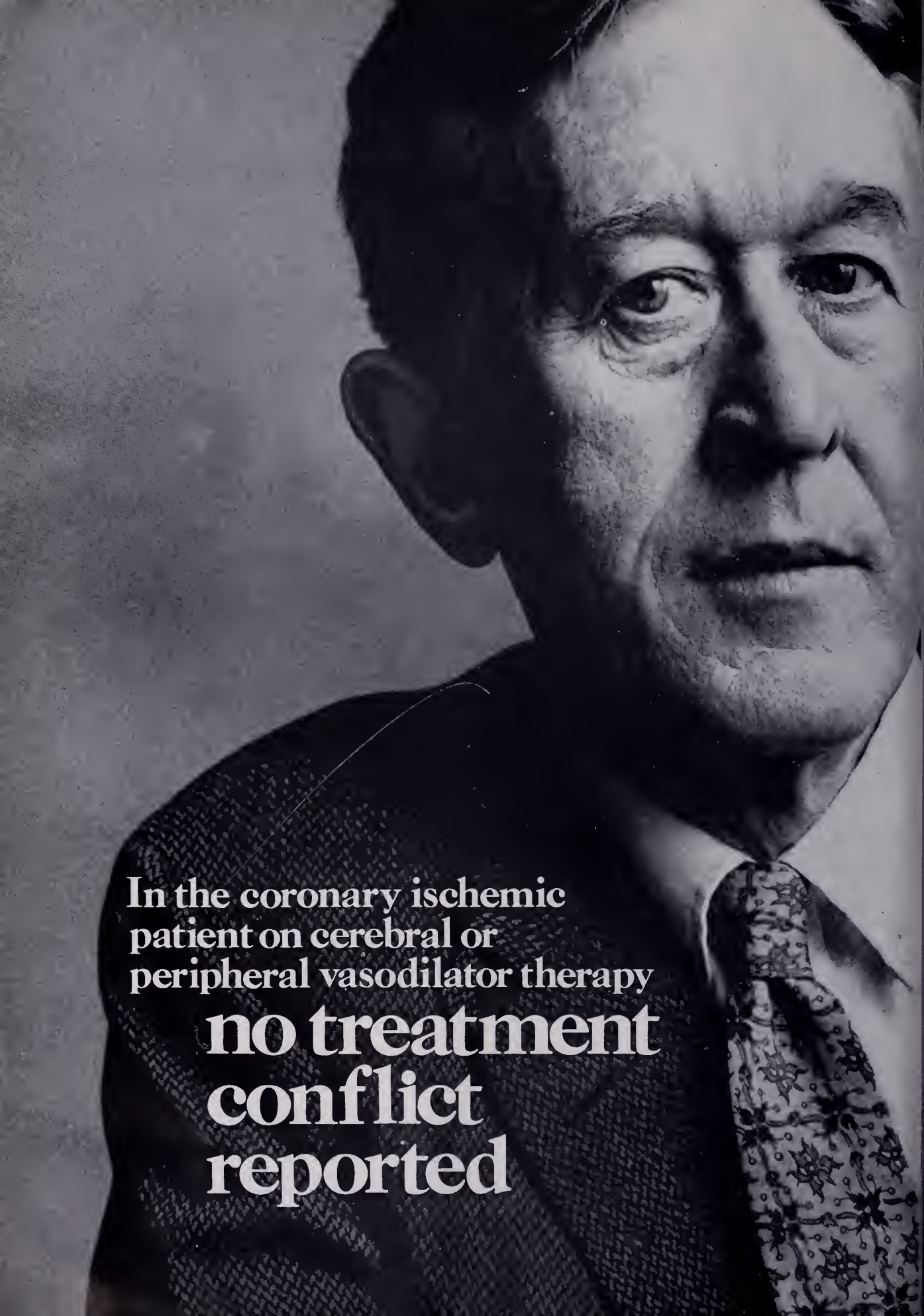
A Change in Policy

A new federal drug agency regulation published October 14, 1971, gives a revised statement of the general policy on fixed combination drugs. Prefaced by the numerous comments received in response to the controversial proposal, wherein more than a thousand physicians submitted letters plus adverse opinions from representatives of organized medicine, all principally objecting to policies being promulgated prior to consulting practicing physicians, the possible threat of removing most combination drugs from the market, increasing drug costs and safety hazards resulting in an impairment of medical and dental practice with decreased convenience for physicians and patients; the commissioner of FDA stated that the new regulations as amended will not remove any combination drugs which meet the criteria described, are restricted to prescription items and will not effect over the counter drugs. The amendment to the regulation is as follows:

"Two or more drugs may be combined in a single dosage form when each component makes a contribution to the claimed effects and the dosage of each component is such that the combination is safe and effective for a significant patient population . . . approval is given when a component is added to enhance the safety or effectiveness of the principal active component and to minimize the potential for abuse of the principal active component. Fixed combination prescription drugs for humans must be determined effective based on evaluation by the National Academy of Science-National Research Council."

Camphorated Tincture of Opium to Become Prescription Drug

On October 20, 1971, the Food and Drug Administration published a proposal in the Federal Register which would require Paregoric to become a prescription drug. If no adverse comments were filed with the FDA within 30 days, the FDA will publish a final order concerning the prescription status for Paregoric.


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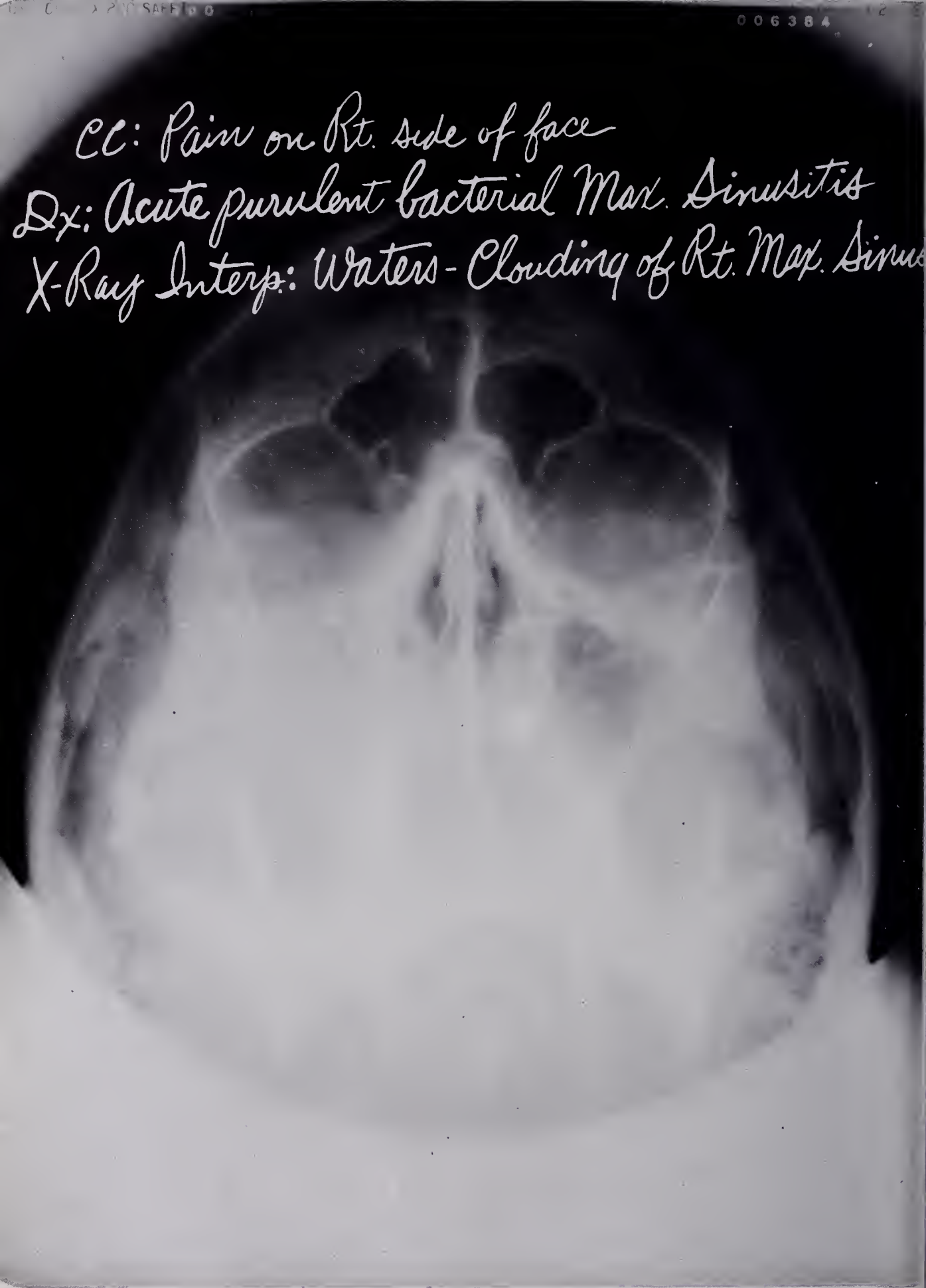
- may be used in your patients with coronary insufficiency.
- conflicts have not been reported with diuretics, corticosteroids, antihypertensives or miotics.
- complications in the treatment of diabetes hypertension, peptic ulcer, glaucoma or liver disease have not been reported.

In fact, there are no known contraindications in recommended oral doses other than it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Although not all clinicians agree on the value of vasodilators in vascular disease, several investigators[1-4] have reported favorably on the effects of isoxsuprine. Effects have been demonstrated both by objective measurement[2,4] and observation of clinical improvement.[1,3]
Indications: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). Composition: VASODĪLAN tablets, isoxsuprine HCl 10 mg. and 20 mg. Dosage: Oral—10 to 20 mg. t.i.d. or q.i.d. Contraindications and Cautions: There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial bleeding. Side Effects: Occasional palpitation and dizziness can usually be controlled by dosage reduction. Complete details available in product brochure from Mead Johnson Laboratories. References: (1) Clarkson, I. S., and LePere, D. M.: Angiology *11*:190-192 (June) 1960. (2) Horton, G. E., and Johnson, P. C., Jr.: Angiology *15*:70-74 (Feb.) 1964. (3) Dhrymiotis, A. D., and Whittier, J. R.: Curr. Ther. Res. *4*:124-128 (April) 1962. (4) Whittier, J. R.: Angiology *15*:82-87 (Feb.) 1964.

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X-ray provided by Manhattan Eye, Ear and Throat Hospital

Dean's Page

Is There a Shortage?

Donn L. Smith, M.D.

"Far more menacing than any possible reduction in the number of physicians is the growth of competition among physicians in the large cities, while the number of physicians in the rural districts, in many places, is decreasing so rapidly that frequently there are no physicians for miles around." This statement, which serves as an introduction to this page, was made by Theodor Billroth almost one hundred years ago (1876) in his book on Medical Education in Germany, translated into English by William Welch in 1924. That Billroth's statement should be so appropriate relative to the same problem in the United States in 1972 indicates that maldistribution of medical manpower is an old and, to date, largely unsolved problem. This significant element of the problem relates to the context in which it exists relative to the socioeconomic situation of the times. The magnitude of the problem in Germany in 1876 in no way compares to the critical nature of the same problem in the United States now.

The pressures brought to bear on the problem in our modern culture lead most observers to believe that some solution will be forthcoming much more rapidly than has been the case in the past. Improved communications, a better informed public, and the political merits of espousing the right to effective health care for every citizen represent potent forces acting against much further delay in the alleviation of the maldistribution of health manpower. Not only the rural areas, but the inner city areas of many large metropolitan areas suffer from a lack of medical manpower. As the flight from the rural communities continues, the situation relative to health care in the inner cities will undoubtedly become more critical.

Having set the stage for an old problem in its current and very critical context, the possible solutions become highly relevant. It is unfortunate that to date we appear to have more questions than answers. Some significant questions that may be asked are: Is there a true shortage of physicians or is it a simple maldistribution of physicians at the root of the problem? What is the probable effect of the lack of appropriate medical facilities in a given area relative to the number of doctors willing to practice there? What is the long-term impact on the problem of the continuing trend toward specialization? These and many more questions all bear on the situation and must inevitably bring influence to bear on any workable solution.

The responsibility and obligations of the Colleges of Medicine in the production of a solution have been widely debated. That the colleges must become more intimately involved in the delivery of health care is an accepted fact among most medical educators. That the schools of medicine can become so involved only in harmony and in a functional interface with the practicing medical community is a second fact that is accepted by most responsible educators. The probable success of a more active participation in health delivery by the schools of medicine in bringing about a successful solution to area manpower shortages and maldistribution of physicians is by no means a measurable or agreed upon fact. All of this places the medical school, as presently organized and constituted, in a very difficult position. Can we, as educators, be all things to all people; can we respond to the massive social pressures being focused upon the profession in a meaningful way and excel in our primary objectives; all in an atmosphere of fiscal deprivation and room for only a portion of those qualified and desirous of entering the study and practice of medicine? If those of us working in educational institutions are to perform in a creditable manner in answer to these questions, it will most likely be as part of

Dr. Smith is Director of the Medical Center and Dean of the College of Medicine, University of South Florida, Tampa.

a team, including organized medicine, with better financing and in the presence of a substantial reorganization of the structure of both the schools and the health care delivery system.

Of paramount concern to many of us is the possibility that the ultimate solution may force the loss, for our students, of the freedom of choice in the kind of medicine they desire to practice and the location in which they chose to conduct their professional activities. If the problems of maldistribution of medical manpower and shortage of physicians are to be solved by means which require regimentation of the physician and practice by directive, then the medical profession will have lost the very elements which have made it a profession, with the result that the cure may be worse than the disease.

It is to be hoped that the traditional American processes of free enterprise, supply and demand, and freedom of choice for both patients and physicians will emerge as a prominent part of any new system of delivery of health care. The final solution must somehow allow for the maintenance of the present high standards of medical care with extension of this type of care to all those in need of health care. To simply provide increased amounts of lower standard medical service will not, in the long run, solve anyone's problems. To provide a poor quality of care to more people because such care is slightly better than none is no effective solution, and in the final analysis may destroy medicine as a profession.

▶ Dr. Smith, University of South Florida, Tampa 33620.

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Medical News

PG Surgical Seminar in Miami Beach

A seminar on "Art and Science in the Therapy of Difficult Problems in Surgery" will be held in Miami Beach, January 12-15, under the sponsorship of the University of Miami School of Medicine.

Programs will relate to surgical care, transplantation, the pancreas and pediatric surgery. Tuition is $100.

The American Academy of Family Practice has approved the program for 16 hours of credit. Additional information may be obtained by contacting: Robert Zeppa, M.D., University of Miami School of Medicine, P.O. Box 875, Biscayne Annex, Miami, Fla. 33152.

Lakeland M.D. Heads SMA Section

Coy Lay, M.D., of Lakeland, was elected Chairman of the Section on Gynecology of the Southern Medical Association during the SMA Annual Meeting in Miami Beach in November.

Health Planning Council Elects Officers

Irving E. Hall, M.D., of Bradenton, has been elected Chairman of the Florida Health Planning Council (Comprehensive Health Planning).

Dr. Hall was elected at a Council meeting in Jacksonville to succeed Samuel M. Day, M.D., of Jacksonville, who retired from the Executive Committee after four years as Chairman. Dr. Day was presented with a plaque and a letter of appreciation from Gov. Reubin Askew.

Also retiring from the Executive Committee after four years was Mr. W. Harold Parham of Jacksonville, Executive Vice President of the Florida Medical Association.

Elected Vice Chairman was State Sen. Beth Johnson (R-Cocoa Beach). Other members of the Executive Committee are Harold Pattishall, D.D.S., of Jacksonville; Mr. Douglas Endsley of Jacksonville, Director of the Florida Division of Family Services; Mr. Richard Pride of Tampa; Carl Andrews, M.D., of West Palm Beach; and Hazel Peeples, R.N., of Jacksonville.

Dr. Frank Moya Is Re-Elected

Frank Moya, M.D., of Miami, has been re-elected Vice President for Scientific Affairs of the American Society of Anesthesiologists.

Dr. Moya is Professor and Chairman of the Department of Anesthesiology and Associate Dean, University of Miami School of Medicine.

Neuromuscular Clinic Established

The University of Miami School of Medicine has established a monthly Neuromuscular Clinic at National Children's Hospital, University of Miami Hospitals and Clinics.

The clinic is under the supervision of the Department of Neurology, with Ricardo Garcia-Mullin, M.D., Assistant Professor of Neurology, in charge.

New Orleans Graduate Medical Assembly

Twenty outstanding clinicians have accepted invitations to present papers at the 35th annual New Orleans Graduate Medical Assembly, March 6-9.

The sessions at the Fairmont Roosevelt Hotel also will include medical motion pictures, round-table luncheons and a CPC.

A symposium on "Our Polluted Environment—Its Problems for the Clinician" will precede the medical meeting on Sunday, March 5.

See additional information on page 11.

Signing Out to ER Discouraged

Physicians who have a habit of signing out to the emergency room may be inviting trouble, a recent legal opinion indicates.

The opinion, rendered by FMA attorney Harry T. Gray of the Jacksonville firm of Marks, Gray, Conroy & Gibbs, points out that a private hospital is not obligated to accept any patient nor is an emergency room physician so obligated.

Doctors who look to emergency rooms to cover their practices at night and on weekends are putting "an unexpected and unanticipated load on a vital service of the hospital and its medical staff," the opinion states. "This practice can cause delay to many emergency patients in receiving needed emergency treatment."

He suggested that the hospital and its medical staff should determine if this practice should be available to staff members.

A copy of the opinion may be obtained by writing to: Department of Communications, Florida Medical Association, P.O. Box 2411, Jacksonville, Fla. 32203.

Miami Physician Gets SMA Post

Walter C. Jones III, M.D., of Miami, was elected second vice president of the Southern Medical Association during the organization's annual meeting in Miami Beach in November.

Dr. Jones' father is a past president of both the SMA and the Florida Medical Association.

BME Issues 2,097 Licenses in 1971

The Florida State Board of Medical Examiners issued 2,097 licenses to physicians to practice medicine in Florida during 1971, according to George S. Palmer, M.D., Executive Director of the Board.

1,961 physicians were licensed as a result of examinations conducted by the Board in January and July. Another 136 doctors were licensed under the 1971 endorsement amendment to the Medical Practice Act. In addition, the Board granted 16 one-year Medical Faculty Certificates.

The Board has decided to act on applications for licenses by endorsement four times a year—in January, April, July and October. Dr. Palmer said applications for a license by endorsement should be submitted to his office at least one month prior to each Board meeting.

The 1971 amendment authorizes BME to issue, without written examination, licenses to physicians who have passed either the examination of the National Board of Medical Examiners or the FLEX examination within the eight-year period immediately preceding application. However, the Board may require such candidates to submit to oral examination.



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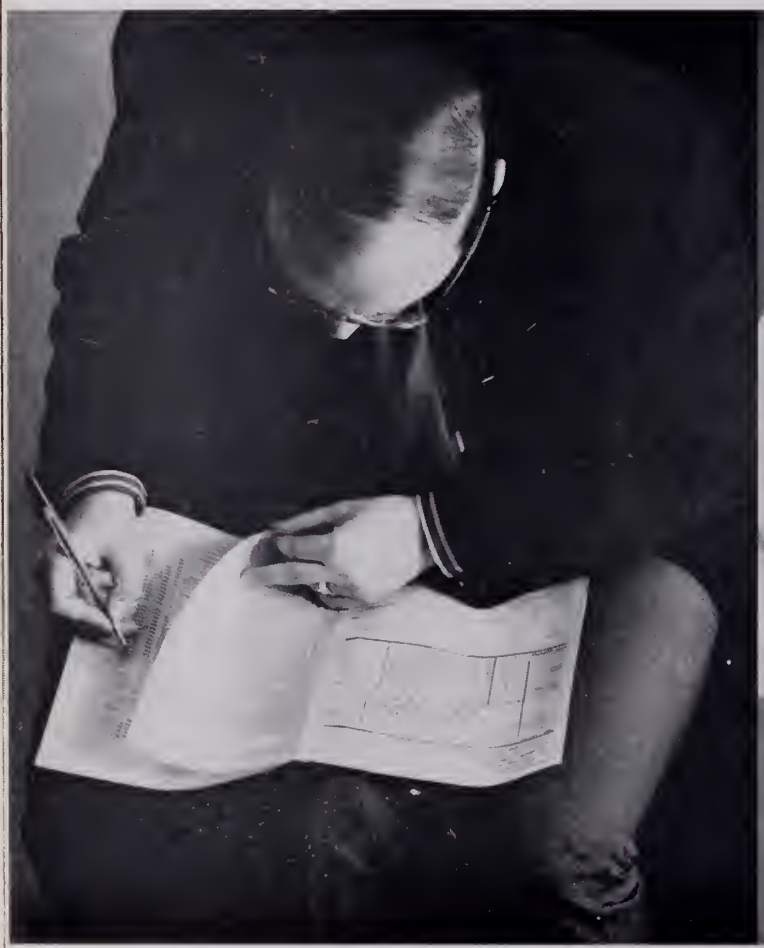
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ORGANIZATION

Doctor's Role in Driver Licensing

Many physicians in Florida are called upon from time to time to appraise the mental and physical ability of a patient to operate a motor vehicle.

In order to simplify this procedure and make it as painless as possible, a form has been developed by the Medical Advisory Committee of the Florida Department of Highway Safety and Motor Vehicles. The form, copied by 20 other states, provides information necessary for a valid assessment of the license applicant's ability to drive.

When one of these forms is sent to a physician, he is asked to complete parts pertaining to history, mental condition, hearing and visual ability of the applicant. Also, certain other parts, checked in red, must be completed. The form states that the information is to be completed by the physician; however, it is acceptable and expected that this could be completed by a nurse or secretary but not, as is many times done at present, completed by the patient.

All requested information must be included or the form will be returned to the physician and the final decision on license application will be delayed. One important thing frequently overlooked is the patient's signed authorization to submit information to the Department. This is also necessary for the physician's protection.

One question is designed to elicit a frank professional appraisal of physical or mental competency to drive. It states: "Doctor, after having examined this person and *assuming* that he or she is a qualified driver, on the basis of your physical examination, would you be willing to ride with him or her as the operator of a motor vehicle?"

This question does not ask the physician to be a judge of the patient's qualifications to drive but merely asks the physician if he feels the patient has the physical and mental ability to drive an automobile safely.

Film on Physical Therapy

"Decision," a 16-minute 16 mm. sound film about the profession of physical therapy, is being made available by Geriatric Pharmaceutical Corp.

Prepared for students of high school or early college level, the film follows the activity of a therapist through his professional training and practice. The film may be obtained on loan from Mr. Gustave Bardfeld, Director of Clinical Research, Geriatric Pharmaceutical Corp., 397 Jericho Turnpike, Floral Park, N.Y. 11001.

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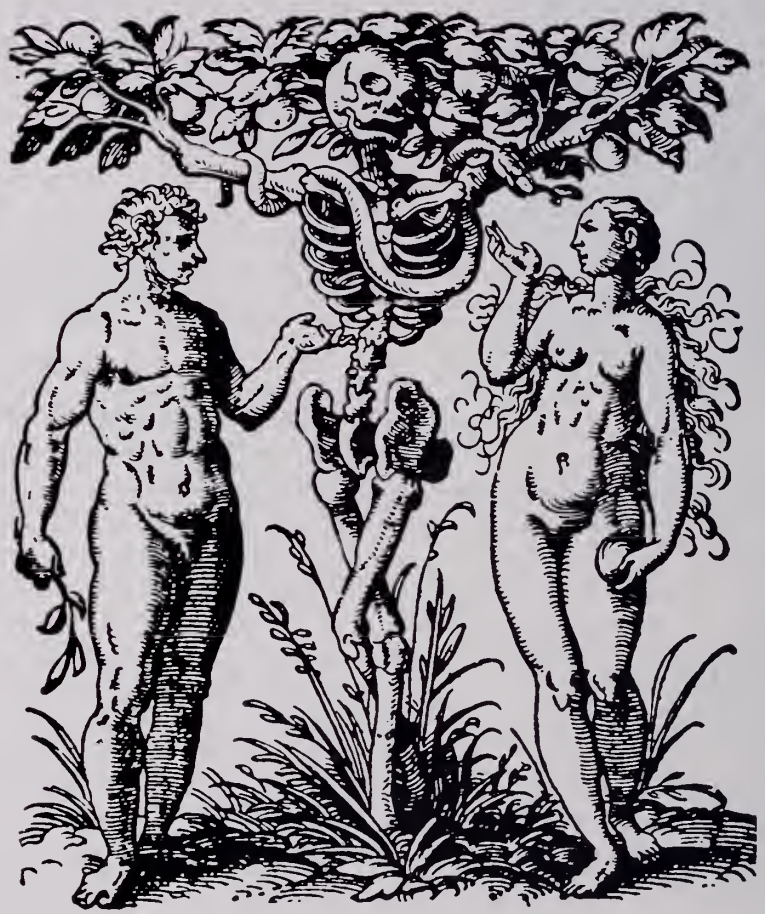
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(urethritis, cervicitis, proctitis when due to susceptible strains of N. gonorrhoeae)



Sterile Trobicin®
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An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between Trobicin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to Trobicin. Not indicated for the treatment of syphilis.

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Warnings: Antibiotics used to treat gonorrhea may ma delay the symptoms of incubating syphilis. Patients shoul carefully examined and monthly serological follow-up f least 3 months should be instituted if the diagnosis of syph suspected.

Safety for use in infants, children and pregnant women ha been established.

Precautions: The usual precautions should be observed atopic individuals. Clinical effectiveness should be monitor detect evidence of development of resistance of *N. gonorrh*

Adverse reactions: The following reactions were obse during the single-dose clinical trials: soreness at the injectio urticaria, dizziness, nausea, chills, fever and insomnia.
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gh cure rate:* 96% of 571 males, 95% of 294 females
osages, sites of infection, and criteria for diagnosis and cure are defined below.)**

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o allergic reactions occurred in patients with an alleged history of penicillin sensitivity hen treated with Trobicin, although penicillin antibody studies were not performed

tive against most strains of Neisseria gonorrhoeae in vitro (M.I.C. 7.5-20 mcg/ml)

single two-gram injection produces peak serum concentrations averaging about 0 mcg/ml in one hour (average serum concentrations of 15 mcg/ml present 8 hours after dosing)

te: Antibiotics used in high doses for short periods of time to treat gonorrhea may mask or delay the mptoms of incubating syphilis. Since the treatment of syphilis demands prolonged therapy with any ective antibiotic, and since Trobicin is not indicated in the treatment of syphilis, patients being treated for norrhea should be closely observed clinically. Monthly serological follow-up for at least 3 months should instituted if the diagnosis of syphilis is suspected. Trobicin is contraindicated in patients previously found persensitive to it.

ta compiled from reports of 14 investigators. **Diagnosis was confirmed by cultural identification of *N. gonorrhoeae* on Thayer-rtin media in all patients. Criteria for cure: negative culture after at least 2 days post-treatment in males and at least 7 days post-atment in females. Any positive culture obtained post-treatment was considered evidence of treatment failure even though the low-up period might have been less than the periods cited above under "criteria for cure" except when the investigator determined t reinfection through additional sexual contacts was likely. Such cases were judged to be reinfections rather than relapses or lures. These cases were regarded as non-evaluatable and were not included.

JA72 1648-6

bin, hematocrit and creatinine clearance; elevation of alka- phosphatase, BUN and SGPT. In single and multiple-dose dies in normal volunteers, a reduction in urine output was ed. Extensive renal function studies demonstrated no con-ent changes indicative of renal toxicity.

sage and administration: Keep at 25°C and use within hours after reconstitution with diluent.

le—single 2 gram dose (5 ml) intramuscularly. Patients with norrheal proctitis and patients being re-treated after failure previous antibiotic therapy should receive 4 grams (10 ml). In ographic areas where antibiotic resistance is known to be pre-ent, initial treatment with 4 grams (10 ml) intramuscularly is ferred.

nale—single 4 gram dose (10 ml) intramuscularly.

w supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of spectinomycin dihydrochloride pentahydrate equivalent to 400 mg spectinomycin per ml. For intramuscular use only.

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For additional product information, see your Upjohn representative or consult the package insert.

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Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

Symposium on the Functional Physiopathology of the Fetus and Neonate, Clinical Correlations. Edited by Harold Abramson, M.D. Pp. 182. 61 illustrations. Price $15.00. St. Louis, The C. V. Mosby Company, 1971.

Handbook of Clinical Dermatoglyphs by Musallam S. Elbualy and Joan D. Schindeler. Pp. 64. Price $6.95. Coral Gables, University of Miami Press, 1971.

Synopsis of Pediatrics by James G. Hughes, M.D. Pp. 1141. Illustrated. Price $14.50. St. Louis, The C. V. Mosby Company, 1971.

Speech Pathology by William H. Perkins, Ph.D. Illustrated. Pp. 449. Price $11.75. St. Louis, The C. V. Mosby Company, 1971.

The Human Heart—A Guide to Heart Disease. Second Edition by Brendan Phibbs, M.D. Pp. 247. 102 illustrations. Price $5.75. St. Louis, The C. V. Mosby Company, 1971.

General Ophthalmology by Daniel Vaughan, M.D.; Taylor Asbury, M.D. and Robert Cook, M.D. Pp. 316. Illustrated. Los Altos, California, Lange Medical Publications, 1971.

Dynamics of Violence edited by Jan Fawcett, M.D. Pp. 198. Price $3.95. Chicago, American Medical Association, 1971.

Teeth, Teeth, Teeth by Sydney Garfield, M.D. Pp. 448. Illustrated. Price $9.95. New York, Simon & Schuster, 1969.

Review of Physiological Chemistry by Harold A. Harper, Ph.D. Pp. 529. Illustrated. Price $8.00. Los Altos, California, Lange Medical Publications, 1971.

The Causes, Ecology and Prevention of Traffic Accidents by H. J. Roberts, M.D. Pp. 1016. Illustrated. Price $39.50. Springfield, Ill., Charles C. Thomas, Publisher, 1971.

Shands' Handbook of Orthopaedic Surgery by R. Beverly Raney Sr., M.D. and H. Robert Brashear Jr., M.D. Pp. 543. 419 Illustrations. Price $15.50. St. Louis, The C. V. Mosby Company, 1971.

Management of High-Risk Pregnancy and Intensive Care of the Neonate by S. Gorham Babson, M.D., and Ralph C. Benson, M.D. Pp. 313. 62 illustrations. Price $16.50. St. Louis, The C. V. Mosby Company, 1971.

Handbook of Poisoning by Robert H. Dreisbach, M.D., Ph.D. Pp. 515. Illustrated. Price $6.00. Los Altos, California, Lange Medical Publications, 1971.

Book Review

Think Thin by Thomas M. Quehl, M.D. Pp. 95. Illustrated. Price $4.95. New York, Vantage Press, Inc., 1971.

This is a sound, mature, short little book for the moderately intelligent obese patient who is well motivated. It clearly indicates the personality problems and unhealthy eating habits of most obese patients, while also discussing the occasional organic diseases which might be responsible or contributory. The health hazards of obesity are properly emphasized. The book deals quite honestly with the various diet aids and fads, amphetamines, thyroid and hormone medications, tranquilizers, and hypnosis and puts them in their proper perspective. It concisely emphasizes the essential elements of a sound reducing program, that is, motivation, diet and exercise. The style is a little more rambling than it should be, but all-in-all the book is well written and provides the patient with a sound insight into a difficult problem.

Ronald Schreiber, M.D.
Hollywood

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nd Efudex® (fluorouracil) 5% cream can resolve it.

l it actinic, solar or senile keratoses, ıy regard it as "precancerous."[1,2]

al fluorouracil, considered by some dermatologists to be a major nce in the treatment of multiple solar keratoses,[3,4] offers the physi- a relatively inexpensive alternative to cryosurgery, electrodesic- n and cold knife surgery. Of the topical fluorouracils available, only ex offers 2% and 5% solution and 5% cream formulations—formula- that have proved effective in the treatment of these mutliple lesions.

tal duration of therapy, 2 to 4 weeks.

ies showed that with the 2% and 5% Efudex preparations, the usual tion of therapy was only 2 to 4 weeks.[5] Other studies with topical ouracil revealed that when concentrations of less than 2% were , significant numbers of lesions recurred.[6]

ats the lesions you can't see, too.

ierous lesions, not apparent prior to 2% and 5% Efudex therapy, ifested themselves by definite reactions, while intervening skin ained relatively unaffected.[5] The early eradication of these subclini- sions (which may otherwise have undergone further progression) ably accounts for the reduced incidence of future solar keratoses in nts treated with topical fluorouracil—especially with 5% entrations.[6]

w to identify solar keratoses.

ically, the lesion—a flat or slightly elevated brown to red-brown le—is dry, rough, adherent and sharply defined. Multiple lesions he rule.

dictable therapeutic response.

response to a typical course of Efudex therapy is usually acteristic and predictable. After 3 or 4 days of treatment, erythema ns to appear in the area of keratoses. This is followed by a moderate tense inflammatory response, scaling and occasionally moderate erness or pain. The height of this response generally occurs two s after the start of therapy and then begins to subside as treatment opped. Within two weeks of discontinuing medication, the mmation is usually gone. Lesions that do not respond should iopsied.

ences: 1. Allen, A. C.: *The Skin, A Clinicopathological Treatise*, ed. 2, New York, e & Stratton, 1967, p. 842. 2. Dillaha, C. J.; Jansen, G. T, and Honeycutt, W. M.: atment of Actinic Keratoses with Topical Fluorouracil," in Waisman, M. (ed.): *maceutical Therapeutics in Dermatology*, Springfield, Ill., Charles C Thomas, 1968, 3. Belisario, J. C.: *Cutis*, *6*:293, 1970. 4. Sams, W. M.: *Arch. Derm.*, *97*:14, 1968. ta on file, Hoffmann-La Roche Inc., Nutley, New Jersey. 6. Williams, A. C., and , E.: *Cancer*, *25*:450, 1970.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

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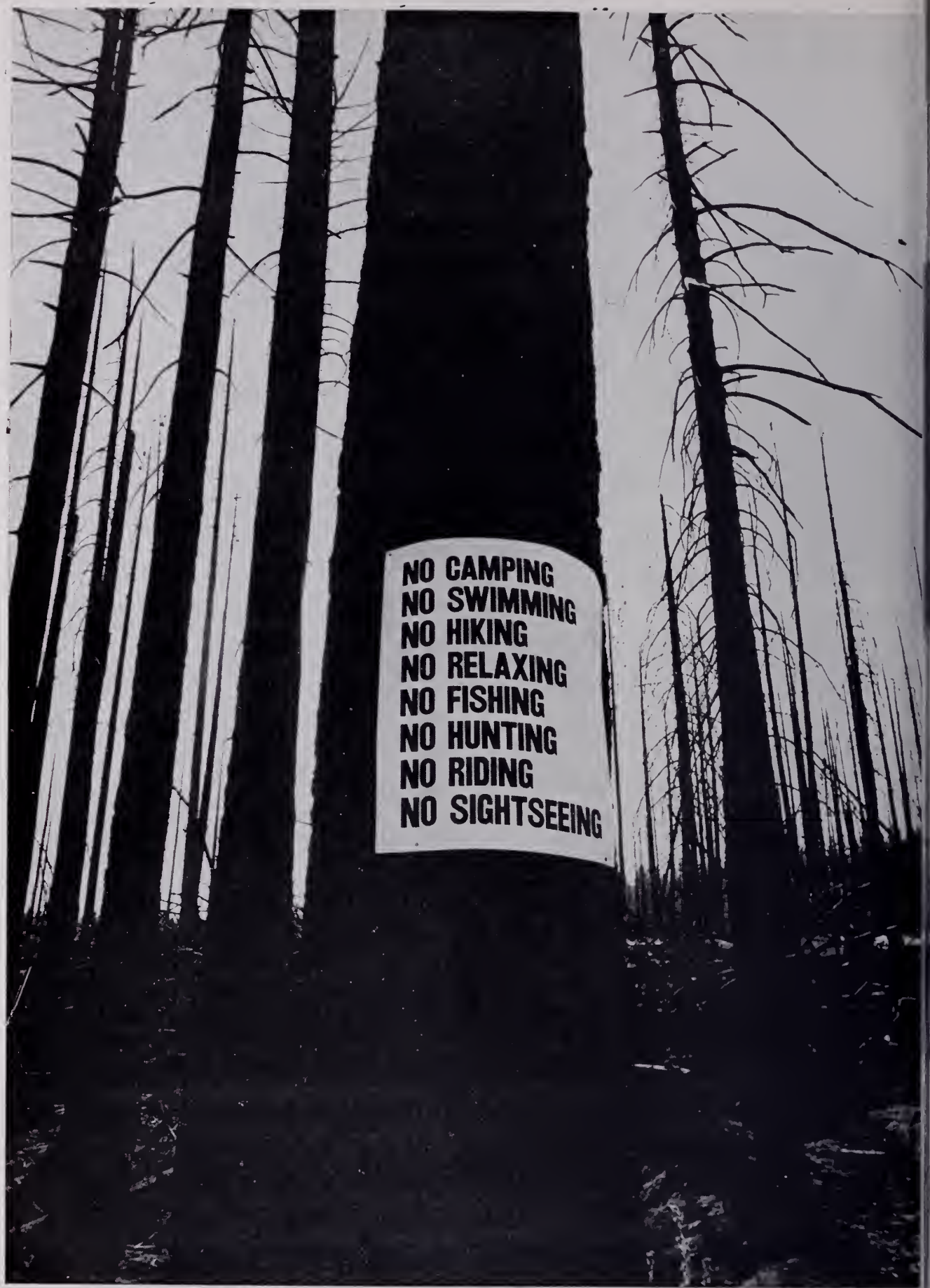


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MEETINGS

Approved by FMA Committee on Continuing Education

JANUARY

11-16 Special Procedures: Radiological Interpretations, Playboy Plaza, Miami Beach. For information: Manuel Viamonte Jr., M.D., Mount Sinai Hospital, 4300 Alton Rd., Miami Beach 33140.

24-29 Courses of Instruction in Coronary Care for the Practicing Physician, Jackson Memorial Hospital, Miami. For information: Louis Lemberg, M.D., P. O. Box 10100, St. Petersburg 33733.

FEBRUARY

13-18 Seventh Annual Postgraduate Course—Internal Medicine 1972, Sheraton-Four Ambassadors Hotel, Miami. For information: J. Bocles, M.D., Box 875, Biscayne Annex, Miami 33152.

MARCH

1- 4 Medical Malpractice, A Legal Course for Physicians, Americana Hotel, Miami Beach. For information: Prof. Walter H. Beckham Jr., Box 8087, Coral Gables, Florida 33124.

4 Sixteenth Watson Clinic Annual Seminar, Watson Clinic, Lakeland. For information: Brunildo A. Herrero, M.D., Watson Clinic, Lakeland, Florida 33802.

15-18 Fourth Teaching Conference in Clinical Cardiology, Sheraton-Four Ambassadors Hotel, Miami. For information: Michael S. Gordon, M.D., Box 875, Biscayne Annex, Miami 33152.

15-19 Fourth Annual Nuclear Medicine Seminar, Playboy Plaza Hotel, Miami Beach. For information: Susan R. Cohen, B.A., Div. of Nuclear Medicine, Box 875, Biscayne Annex, Miami 33152.

21-25 Selected Topics in Gastrointestinal Roentgenology, Fontainebleau Hotel, Miami Beach. For information: Manuel Viamonte Jr., M.D., Box 875, Biscayne Annex, Miami 33152.

National and Regional Meetings Held in Florida

JANUARY

17-19 American College of Surgeons, Sectional Meeting. Sheraton-Four Ambassadors Hotel, Miami. Info. Communications Division, 55 E. Erie St., Chicago 60611.

FEBRUARY

28-Mar. 3 American Society of Contemporary Medicine, Diplomat Hotel, Hollywood. Dir.: John Bellows, M.D. , 30 N. Michigan Ave., Chicago 60602.

28-Mar. 3 American Society for Contemporary Ophthalmology, Diplomat Hotel, Hollywood. Dir.: John Bellows, M.D., 30 N. Michigan Ave., Chicago 60602.

28-Mar. 3 Society of Cryosurgery, Diplomat Hotel, Hollywood. Dir.: John Bellows, M.D., 30 N. Michigan Ave., Chicago 60602.

APRIL

3- 8 American College of Radiology, Fontainebleau Hotel, Miami Beach. Ex. Dir.: William C. Stronach, J. D., 20 N. Wacker Dr., Chicago 60606.

18-20 American Academy of Facial Plastic and Reconstructive Surgery. Sec.: Carl N. Patterson, M.D., 1110 W. Main St., Durham, North Carolina 27701.

23-24 American Otological Society, Breakers Hotel, Palm Beach. Sec.: Wesley H. Bradley, M.D., 1111 E. Genessee St., Syracuse, N.Y. 13210.

24-25 American Broncho-Esophagological Association, Hollywood Beach Hotel, Hollywood. Walter H. Maloney, M.D., 2065 Adelbert Rd., Cleveland 44106.

Florida State Board of Medical Examiners:
July 23-25, 1972, Miami Beach

For information: Mrs. Marjoriann Keebler, Administrative Assistant, Florida State Board of Medical Examiners, 2717 E. Oakland Pk. Blvd., Fort Lauderdale, Fla. 33306.

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Classified Ads

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. *Important Note:* Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response. Add aminobenzoic acid to culture media for patients already taking sulfonamides. Increasing frequency of resistant organisms currently is a limitation of the usefulness of antibacterial agents. Blood levels should be measured in patients receiving sulfonamides for serious infections, since there may be wide variations with identical doses; 12 to 15 mg/100 ml is considered optimal for serious infections; 20 mg/100 ml should be the maximum total sulfonamide level, as adverse reactions occur more frequently above this level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period. Contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with gastrointestinal disturbances, because of phenazopyridine HCl component.

Warnings: Safe use in pregnancy has not been established, and teratogenicity potential has not been thoroughly investigated. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported; clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts and urinalysis with careful microscopic examination should be performed frequently during sulfonamide therapy.

Precautions: Use with caution in patients with impaired renal or hepatic function, severe allergy, bronchial asthma and in glucose-6-phosphate dehydrogenase-deficient individuals. In the latter, hemolysis, a frequently dose-related reaction, may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia; *allergic reactions:* erythema multiforme (Stevens-Johnson syndrome), skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis; *gastrointestinal reactions:* nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis; *C.N.S. reactions:* headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia; and *miscellaneous reactions:* drug fever, chills, toxic nephrosis with oliguria and anuria, polyarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide and thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Usual adult dosage for acute, painful phase of urinary tract infection is 4 tablets initially, then 2 tablets morning and evening. If pain persists beyond seven days, causes other than infection should be sought. After relief has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

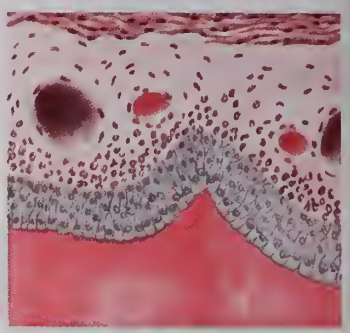
NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine soon after ingestion.

How Supplied: Tablets, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl, bottles of 100 and 500.

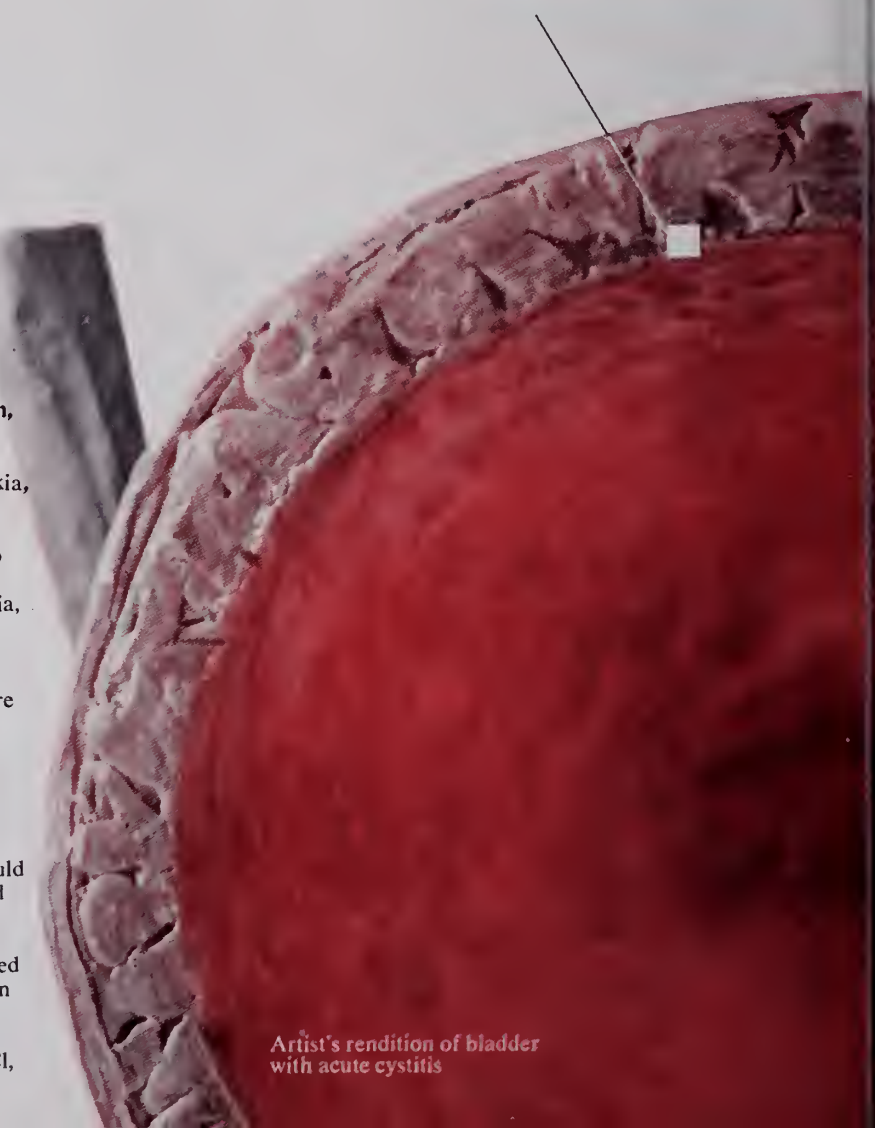
Azo

Each tablet contains 100 mg phenazopyridine H

for dramatic relief from symptoms within minutes



Artist's rendition of inflamed mucosa of the bladder wall

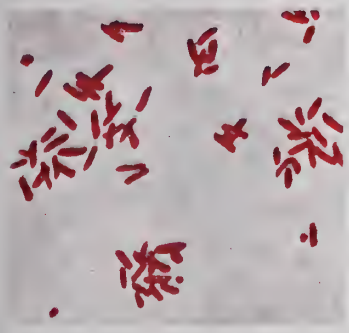


Artist's rendition of bladder with acute cystitis

Gantanol®

ıl 0.5 Gm sulfamethoxazole.

for effective antibacterial action within hours



Artist's rendition of *E. coli*



Rapid relief of discomfort

The patient needs prompt relief of urinary bladder pain and the physician needs to initiate early antibacterial action to fight the infection. This is where the basic therapy of dual-action Azo Gantanol® can help... the analgesic action of Azo (phenazopyridine HCl) for prompt relief from bladder pain and the effective actio.. of Gantanol® (sulfamethoxazole) to control the bladder infection.

Antibacterial blood/urine levels in from 2 to 3 hours

With the initial 2-Gm dose, the analgesic action of the Azo component starts immediately to relieve the symptoms associated with an infected and inflamed bladder. In from 2 to 3 hours, as effective antibacterial blood and urine levels are reached, the Gantanol action begins to control the bacteria most often implicated in acute infections of the bladder... susceptible *E. coli* as well as susceptible strains of *Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis,* and, less frequently, *P. vulgaris.* The usual precautions in sulfonamide therapy, including maintenance of adequate fluid intake, should be observed. The most common side effects are nausea, vomiting and diarrhea.

12 hours of therapy with every dose

Subsequent *b.i.d.* doses of 1 Gm, morning and evening, maintain effective antibacterial coverage on a round-the-clock basis. With every dose, Azo Gantanol helps relieve the symptoms of cystitis while it fights the infection.

In acute painful nonobstructed cystitis

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FEBRUARY COVER: Another of Florida's beautiful scenic attractions, Cypress Gardens.

¿Habla español?

f not, the new Rocom -ealth History Questionnaire sks questions in Spanish...

provides answers in English

Le molestan coyunturas o músculos rígidos o dolorosos?	1.	Sí X	No
Se le hinchan las coyunturas?	2.	Sí	No X
Le molestan dolores en la espalda u hombros?	3.	Sí X	No
Le duelen los pies con frecuencia?	4.	Sí	No X
Está desabilitado en alguna manera?	5.	Sí	No X
Tiene algun problema con su piel?	6.	Sí	No X
Le pica o quema la piel?	7.	Sí	No X
Sangra por largo tiempo cuando se hace una pequeña cortadura?	8.	Sí	No X
Se lastima facilmente formando un cardenal o morete?	9.	Sí	No X
Se ha desmayado o se ha sentido como que se va a desmayar?	10.	Sí	No X
Tiene alguna parte del cuerpo siempre adormecida?	11.	Sí X	No
Ha tenido alguna vez convulciones?	12.	Sí	No X
Le ha cambiado ultimamente su letra al escribir?	13.	Sí	No X
Tiene tendencia a temblar o menearse mucho?	14.	Sí	No X
Se pone nervioso en presencia de personas extrañas?	15.	Sí X	No
Se le hace difícil tomar decisiones?	16.	Sí X	No
Se le hace difícil concentrar o recordar?	17.	Sí X	No
Se siente solo o deprimido?	18.	Sí	No X
Llora a menudo?	19.	Sí	No X
Diría usted que tiene una perspectiva irremediable?	20.	Sí	No X
Tiene dificultad en relajar o reposar?	21.	Sí X	No
Tiende a preocuparse demasiado?	22.	Sí X	No
Le molestan o asustan algunos sueños o pensamientos?	23.	Sí	No X
Tiende a ser tímido o sensitivo?	24.	Sí	No X
Se molesta mucho cuando lo critican?	25.	Sí X	No
Pierde el genio con frecuencia?	26.	Sí X	No
Cosas pequeñas lo hacen molestar?	27.	Sí X	No
Le molesta cualquier trabajo o problemas familiares?	28.	Sí	No X
Tiene algún problema con su vida sexual?	29.	Sí	No X
Ha considerado alguna vez suicidarse?	30.	Sí	No X
Ha deseado alguna vez, o buscado, ayuda psiquiatrica?	31.	Sí X	No

ght © 1971 Patient Care Systems, Inc. All rights reserved.

13. MUSCULOSKELETAL
- X aching muscles or joints
- ___ swollen joints
- X back or shoulder pains
- ___ painful feet
- ___ handicapped

14. SKIN
- ___ skin problems
- ___ itching or burning skin
- ___ bleeds easily
- ___ bruises easily

15. NEUROLOGICAL
- ___ faintness
- X numbness
- ___ convulsions
- ___ change in handwriting
- ___ trembles

16. MOOD
- X nervous with strangers
- X difficulty making decisions
- X lack of concentration or memory
- ___ lonely or depressed
- ___ cries often
- ___ hopeless outlook
- X difficulty relaxing
- X worries a lot
- ___ frightening dreams or thoughts
- ___ shy or sensitive
- X dislikes criticism
- X loses temper
- X annoyed by little things
- ___ work or family problems
- ___ sexual difficulties
- ___ considered suicide
- X desired psychiatric help

n your patient speaks little English and your Spanish is ed or nonexistent, you need the new ROCOM Health History stionnaire (Spanish).*

ne uniqueness of this new ROCOM system lies in the fact the questions are asked in *Spanish,* but you read the answers *nglish.* The form itself does the "translating."

ou have to see it yourself to appreciate the ease and pleteness of this new history-taking technique, which includes 2 questions covering all body systems.

ed and developed by Patient Care Systems, Inc.

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Specialty _____

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This modern psychiatric hospital is now fully operational. With completion of the comfortable seclusion rooms and lounge complex, Lakeland Manor is prepared to offer full psychiatric services. Treatment procedures are geared to the most modern concepts of psychiatry. Treatment includes intensive dynamic psychotherapy for the individual, group psychotherapy, chemotherapy, occupational and recreational therapy. Every effort is made to create a highly therapeutic milieu. Patients are admitted on referral of their physicians either on a voluntary basis or commitment. All types of emotionally ill patients are accepted, including those with alcohol addiction. All patients are treated by private psychiatrists who make regular reports to the referring physician on the patient's progress.

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Pre-Sate® (chlorphentermine hydrochloride)

Caution: Federal law prohibits dispensing without prescription.

Indications
Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (i.e. several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.

Contraindications
Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.

Warnings
When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.
Drug Dependence Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with the high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.
Usage In Pregnancy The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.
Usage In Children Not recommended for use in children under 12 years of age.

Precautions
In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorectic agent and a restrictive dietary regimen.

Adverse Reactions
Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.

Dosage and Administration
The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.

Overdosage
Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.
Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

How Supplied
Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.

Full information is available on request.

President's Page



Physical Fitness

Many benefits are derived from a proper program to increase physical fitness. The aim of such an adult training program is not to increase athletic skill or performance, or to develop special skills for vocational activities, it is simply to prepare a person better to meet the unavoidable extraordinary stresses which occur in everyday living.

This is accomplished in part by improving the mechanical efficiency with which muscular performance is executed, thus reducing the oxygen required to do this work. Such an individual has an improved capability for relaxation; he can endure a greater degree of fatigue, and his central nervous system shows an improved adjustment to acidemia. He loses some of his fat deposits and the muscular tone is augmented; there is less sag to his body, he can do more and recovers from exertion and stress more rapidly. He carries out exercise with less extraneous waste motion and his muscles are increased in mass and vascularity. His liver releases glucose more readily and better metabolizes the acids produced during exercises. Blood volume is increased, as is the amount of hemoglobin and the number of red blood cells. As a result, the oxygen carrying capacity of the blood is increased. Specifically, in the case of the heart, training slows its rate at rest and for each level of exercise below that observed in the untrained person, the amount of oxygen available to the body for each stroke of the heart is increased. Increased cardiac output is supplied by increased stroke output in the trained more than in the untrained individual, and the relatively increased stroke output is at the expense of the systolic residue, or the residue remaining after the heart contracts. There is evidence also that the heart hypertrophies, or increases in size. All of these factors tend to increase the maximum cardiac output.

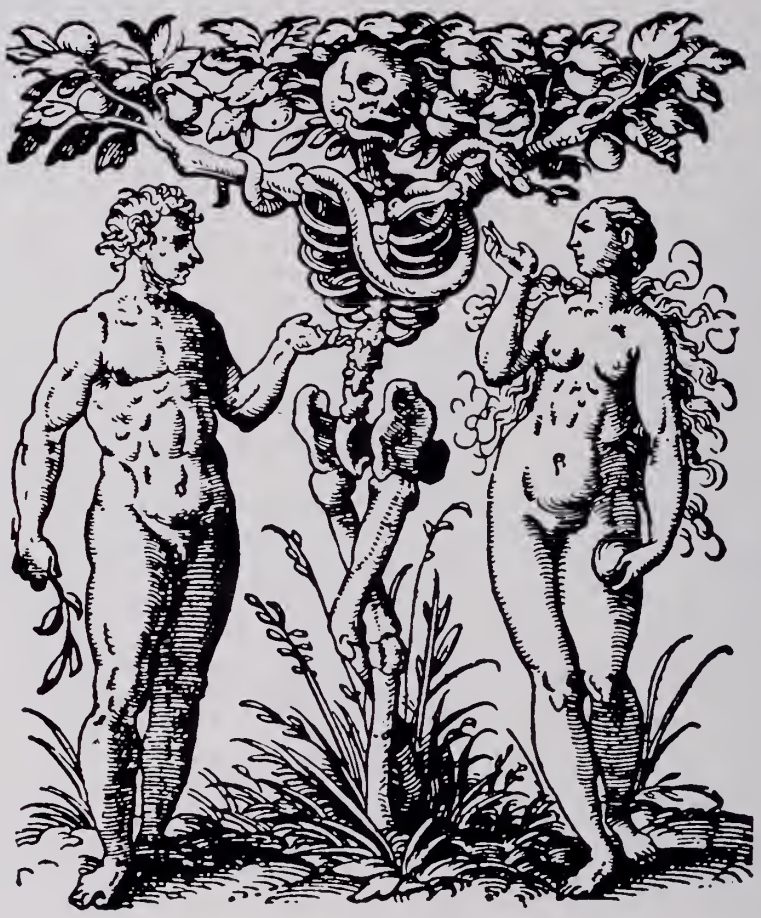
At any exercise level the heart spends more of its time in diastole in the trained than in the undertrained individual. This is due to a slower rate, as well as shortening of the injection period considered in its relation to the heart rate. This gives opportunity for rest to the heart. It is the altered behavior of the heart after training with the resulting decline in its own requirement for oxygen and coronary blood flow which holds the great promise for training in the cardiac patient, particularly in those with coronary heart disease.

The training program is best begun and continued for some time under professional supervision, or at least in groups, rather than by the individual alone. Only after he has been through such a program and knows how to continue can he undertake to maintain the periodic exercise schedule prescribed to keep him fit. Ultimately, health is an individual matter, and if there is one lesson to be learned from mortality statistics it is that the most important thing to be done for the health of the individual and the nation is for each American to understand what he needs to do in his own interest . . . and then to do it.

D. K. Hurst M.D.

In acute gonorrhea

(urethritis, cervicitis, proctitis when due to susceptible strains of N. gonorrhoeae)



Sterile Trobicin®
(spectinomycin dihydrochloride pentahydrate)—For Intramuscular injections, 2 gm vials containing 5 ml when reconstituted with diluent. 4 gm vials containing 10 ml when reconstituted with diluent.
An aminocyclitol antibiotic active *in vitro* against most strains of *Neisseria gonorrhoeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonorrhoeae* between Trobicin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute gonorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. gonorrhoeae*.

Contraindications: Contraindicated in patients previously found hypersensitive to Trobicin. Not indicated for the treatment of syphilis.

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Warnings: Antibiotics used to treat gonorrhea may m
delay the symptoms of incubating syphilis. Patients shou
carefully examined and monthly serological follow-up
least 3 months should be instituted if the diagnosis of syp
suspected.

*Safety for use in infants, children and pregnant women h
been established.*

Precautions: The usual precautions should be observe
atopic individuals. Clinical effectiveness should be monito
detect evidence of development of resistance of *N. gonorrh*

Adverse reactions: The following reactions were obs
during the single-dose clinical trials: soreness at the injectio
urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic tolerance studies in r
human volunteers, the following were noted: a decrease in

Trobicin®

sterile spectinomycin dihydrochloride pentahydrate, Upjohn

single-dose intramuscular treatment

h cure rate:* 96% of 571 males, 95% of 294 females
sages, sites of infection, and criteria for diagnosis and cure are defined below.)**

urance of a single-dose, physician-controlled treatment schedule

allergic reactions occurred in patients with an alleged history of penicillin sensitivity en treated with Trobicin, although penicillin antibody studies were not performed

ive against most strains of Neisseria gonorrhoeae <u>in vitro</u> (M.I.C. 7.5-20 mcg/ml)

ingle two-gram injection produces peak serum concentrations averaging about) mcg/ml in one hour (average serum concentrations of 15 mcg/ml present 8 hours after dosing)

te: Antibiotics used in high doses for short periods of time to treat gonorrhea may mask or delay the iptoms of incubating syphilis. Since the treatment of syphilis demands prolonged therapy with any ctive antibiotic, and since Trobicin is not indicated in the treatment of syphilis, patients being treated for norrhea should be closely observed clinically. Monthly serological follow-up for at least 3 months should nstituted if the diagnosis of syphilis is suspected. Trobicin is contraindicated in patients previously found ersensitive to it.

a compiled from reports of 14 investigators. **Diagnosis was confirmed by cultural identification of *N. ganarrhaeae* on Thayer-tin media in all patients. Criteria for cure: negative culture after at least 2 days post-treatment in males and at least 7 days post-tment in females. Any positive culture obtained post-treatment was considered evidence of treatment failure even though the w-up period might have been less than the periods cited above under "criteria for cure" except when the investigator determined reinfection through additional sexual contacts was likely. Such cases were judged to be reinfections rather than relapses or ures. These cases were regarded as non-evaluatable and were not included. JA72 1848-6

in; hematocrit and creatinine clearance; elevation of alka-phosphatase, BUN and SGPT. In single and multiple-dose es in normal volunteers, a reduction in urine output was d. Extensive renal function studies demonstrated no con-nt changes indicative of renal toxicity.

age and administration: Keep at 25°C and use within ours after reconstitution with diluent.
e—single 2 gram dose (5 ml) intramuscularly. Patients with orrheal proctitis and patients being re-treated after failure reviaus antibiotic therapy should receive 4 grams (10 ml). In graphic areas where antibiotic resistance is known to be pre-nt, initial treatment with 4 grams (10 ml) intramuscularly is erred.
ale—single 4 gram dose (10 ml) intramuscularly.

v supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of spectinamycin dihydrochloride pentahydrate equivalent to 400 mg spectinamycin per ml. For intramuscular use only.
Susceptibility Powder—for testing *in vitro* susceptibility of *N. ganarrhaeae*.

Human pharmacology: Rapidly absorbed after intramuscular injection. A two-gram injection produces peak serum concentrations averaging about 100 mcg/ml at one hour with 15 mcg/ml at 8 hours. A four-gram injection produces peak serum concentrations averaging 160 mcg/ml at two hours with 31 mcg/ml at 8 hours.

For additional product information, see your Upjohn representative or consult the package insert. MED-B-1-S (LWB)

Upjohn The Upjohn Company, Kalamazoo, Michigan 49001

Arthur los



A single-dose, non-staining anthelm

is pinworms...



with just one non-staining dose of Antiminth (pyrantel pamoate) Oral Suspension.

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Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia

Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lbs. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day; and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices. Because of limited data on repeated doses, no recommendations can be made.

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ual duration of therapy, 2 to 4 weeks.

lies showed that with the 2% and 5% Efudex preparations, the usual ation of therapy was only 2 to 4 weeks.[5] Other studies with topical ouracil revealed that when concentrations of less than 2% were , significant numbers of lesions recurred.[6]

eats the lesions you can't see, too.

nerous lesions, not apparent prior to 2% and 5% Efudex therapy, ifested themselves by definite reactions, while intervening skin ained relatively unaffected.[5] The early eradication of these subclini- esions (which may otherwise have undergone further progression) ably accounts for the reduced incidence of future solar keratoses in ents treated with topical fluorouracil—especially with 5% centrations.[6]

w to identify solar keratoses.

ically, the lesion—a flat or slightly elevated brown to red-brown ule—is dry, rough, adherent and sharply defined. Multiple lesions the rule.

edictable therapeutic response.

response to a typical course of Efudex therapy is usually acteristic and predictable. After 3 or 4 days of treatment, erythema ins to appear in the area of keratoses. This is followed by a moderate tense inflammatory response, scaling and occasionally moderate derness or pain. The height of this response generally occurs two ks after the start of therapy and then begins to subside as treatment opped. Within two weeks of discontinuing medication, the ammation is usually gone. Lesions that do not respond should iopsied.

ences: 1. Allen, A. C.: *The Skin, A Clinicopathological Treatise*, ed. 2, New York, e & Stratton, 1967, p. 842. 2. Dillaha, C. J.; Jansen, G. T, and Honeycutt, W. M.: atment of Actinic Keratoses with Topical Fluorouracil," in Waisman, M. (ed.): *maceutical Therapeutics in Dermatology*, Springfield, Ill., Charles C Thomas, 1968, . 3. Belisario, J. C.: *Cutis, 6*:293, 1970. 4. Sams, W. M.: *Arch. Derm., 97*:14, 1968. ta on file, Hoffmann-La Roche Inc., Nutley, New Jersey. 6. Williams, A. C., and . E.: *Cancer, 25*:450, 1970.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

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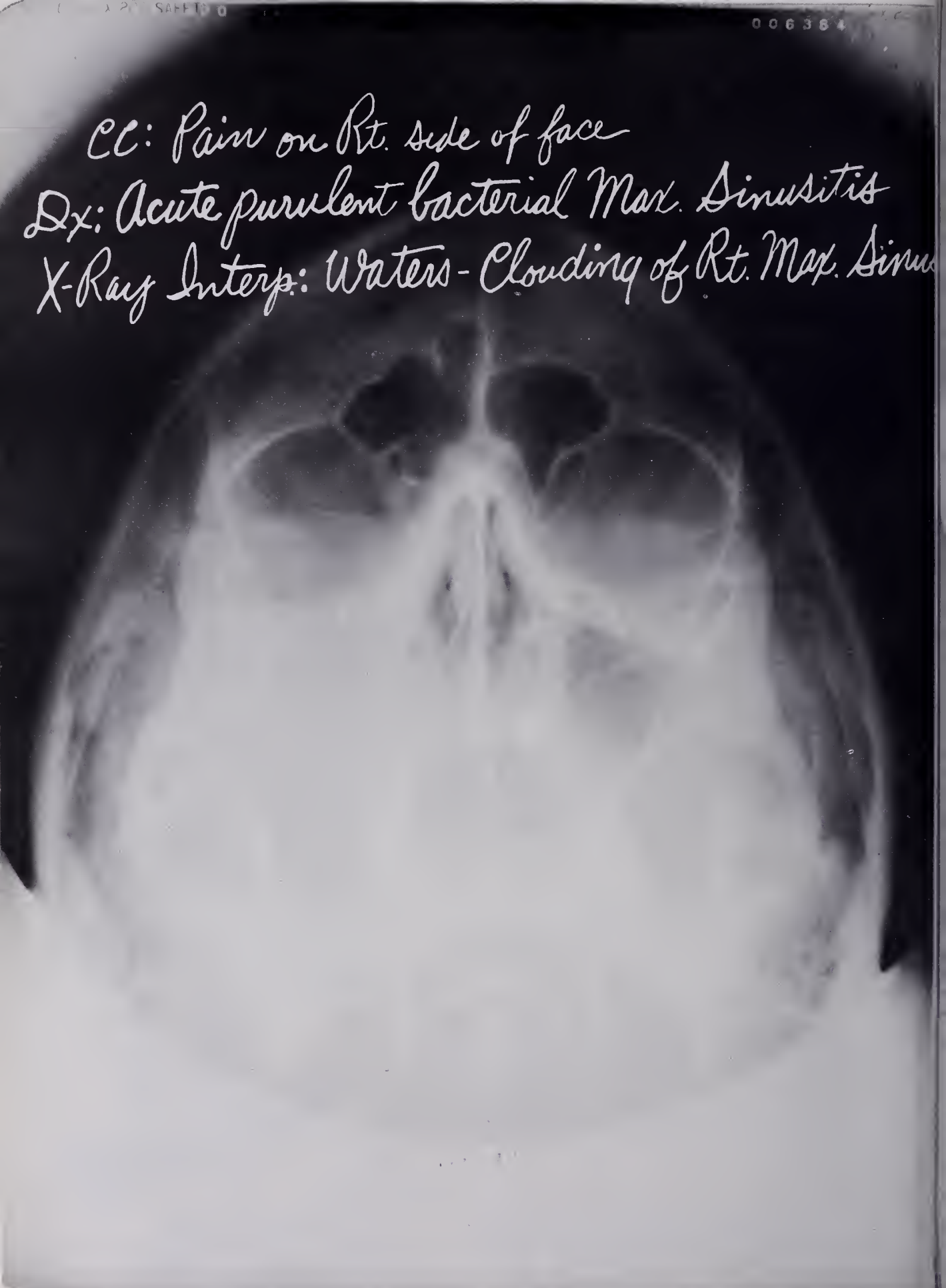


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Treatment of Anovulation With Human Menopausal and Human Chorionic Gonadotropin

JOHN M. SCHULTZ, M.D.

Many attempts have been made to induce ovulation in the treatment of amenorrheic anovulatory infertile women. Recent developments in the isolation and purification of human gonadotropins have provided a satisfactory method of therapy.

In classical experiments in 1926 Zondek[1] and Smith[2] established the presence of gonadotropic activity in the anterior pituitary. Subsequent to this discovery Fluhmann[3] and Zondek[4] working independently noted gonadotropins in the blood and urine of menopausal women.

In 1958 Gemzell and co-workers[5] reported that follicular development and estrogen production followed the administration of human follicle stimulating hormone (FSH) of pituitary origin. Subsequent administration of human chorionic gonadotropin (HCG) frequently elicited ovulation and resulted in pregnancy. Human menopausal gonadotropin (HMG) followed by human chorionic gonadotropin to induce ovulation has been well documented by Rosenberg.[6]

Human menopausal gonadotropin is a proteinaceous extract prepared from the pooled urine of postmenopausal women containing both follicle stimulating hormone and luteinizing hormone (LH) activity. Biological assay utilizing the ovarian augmentation reaction in immature rats reveals a potency of about 75 (70-85) international units (IU) FSH per vial. Assay by the ovarian ascorbic acid depletion method shows 25 + 10 IU LH per vial.

Materials and Methods

The 18 patients in this study either had primary or secondary amenorrhea, irregular menses and all were anovulatory. One patient had polycystic ovaries. There were no patients with primary ovarian failure. All were of reproductive age (21-35) with no pathology of genital tracts. All but two husbands had normal sperm counts. The two husbands with oligospermia, 10 million/cc. and 30 million/cc., did not impregnate their wives.

In addition to the routine infertility work-up,

Dr. Schultz is Clinical Assistant Professor of Obstetrics and Gynecology at the University of Miami School of Medicine, Miami, and also attending gynecologist at Mt. Sinai Hospital, Miami Beach.

Human menopausal gonadotropin used in this study was generously supplied by Dr. Tom Smith of the Ortho Research Foundation, Raritan, N. J. Pregovia is the trademark of Ortho Pharmaceutical Corp.

Human chorionic gonadotropin used in this study was obtained from the Vitamerican Corp., Little Falls, N. J.

i.e., tubal insufflation, endometrial biopsy, semen analysis, postcoital test, fern and spinnbarkeit tests and serial vaginal smears, all the patients had the following:

1. Hysterosalpingogram with Ethiodol or contrast hysterosalpingogram with CO_2 followed by Ethiodol.

2. Under anesthesia all had hydrotubation with 20 cc. saline, 50 mg. streptomycin, 50 mg. cortisone and 5000 IU alphachymotrypsin, followed by tubal insufflation with CO_2.

3. Dilatation and curettage. Those patients with cervicitis had a radial cauterization of the cervix. Pathological report of all patients was proliferative endometrium.

4. Laboratory work-up in the hospital consisted of CBC, urine, T_3 uptake, biochemical profile-16, 17-ketosteroids, 17-hydroxysteroids, follicle stimulating hormone, pregnandiol, pregnantriol and total estrogen determinations.

Prior to the treatment cycle each patient had menses induced with 10 mg. medroxyprogesterone daily for five days. Treatment began on day five of the cycle. The routine to be followed was 2 ampules HMG for nine days, a rest period of two days, then two days of 5000 IU HCG. Daily pelvic examinations to include vaginal smears, spinnbarkeit and fern tests and postcoitals were done. This dosage schedule was most successful and sufficient to cause ovulation. Those patients in whom the estrogen response came earlier and adequate were given one to two less ampules of HMG (Table 1).

The appearance of excellent ferning, copious cervical mucus, increased spinnbarkeit and improved postcoital tests were the clinical indices to estrogen secretion and follicular secretion. Ovulation was assumed with persistent rise in the BBT chart, the disappearance of ferning, decreased spinnbarkeit, and the change in vaginal cytology to that of the luteal phase, and definite in those patients who became pregnant.

Results

There were 12 pregnancies in the group. Patient #3 conceived twice and patient #10 three times. One patient had premature twins at seven months. Both are living and well. Another patient had a seven month premature infant girl that lived 22 hours, but has had two children since without further therapy. Two patients conceived after having a menstrual period after therapy, one the following month and delivered a normal male infant. Two patients had two courses of treatment, one conceived after the second course and delivered a normal female infant. The other patient did not conceive. The husband was oligospermic with counts of 10, 20 and 6 million on different occasions.

One patient not included in this group did not conceive after HMG-HCG therapy but did conceive after the third course of Clomid-HCG treatment and delivered a normal male infant. There were two miscarriages. One patient had a monophasic BBT chart but copious cervical mucus, excellent fern tests, decreased spinnbarkeit evaluations, and excellent postcoital tests throughout the cycle. Unfortunately an endometrial biopsy was not done and this patient was classified as anovulatory (Table 2).

At present in the group of 18 patients there are 12 living children.

Large ovarian cysts with ascites developed in patient #7 following completion of HMG-HCG injections from batch #2225 on day 17. She had marked abdominal distention and both cysts extended above the umbilicus. She was admitted to Mt. Sinai Hospital for six weeks. On admission a pregnancy test proved positive but two repeat tests during the next two weeks were negative. Treatment in the hospital was supportive with intravenous fluids to maintain fluid and mineral balance. Injection treatment had started on April 28, 1967. Vaginal bleeding began on June 10, and abdominal distention reduced by one half in 24 hours and returned to normal in four days. She had profuse urination for two days. A normal female infant was delivered on February 18, 1968. The patient had been pregnant all the time while in the hospital as she did not have coitus for four months from the time she was hospitalized.

Patient #9 also had batch #2225 HMG-HCG, and enlarged ovaries developed (8-10 cm.) with some abdominal distention and pain. She was hospitalized for five days; discharged with normal ovaries when she menstruated two days later.

Patient #14 received batch #2282. During HMG injections she stated she felt bloated and occasionally there was very mild abdominal distention. The ovaries were tender but not enlarged on palpitation. Her dosage schedule was 2 ampules day one, 2 ampules days three and four, 1 ampule day five, 2 ampules day six, 1 ampule day seven, 2 ampules day eight, 2 ampules day ten, 2 ampules day 11, and 1 ampule days 14 and 15.

She delivered twins at seven months; both are living and well.

Patient #11 became pregnant following a second course of Pregovia in March 1968 and had a positive A-Z test on April 24. A normal female infant was delivered on December 28. She is now in the sixth month of pregnancy following a course of Pergonal and x-rays reveal triplets. Triplets were delivered January 21, 1971 at term; boy 7 lbs., 3 oz.; boy 6 lbs., 2¼ oz., and girl 5 lbs., 10 oz. (Pregovia is not available at the present time.)

It is apparent from results reported that sequential therapy with HMG-HCG is efficient in the induction of ovulation. Since HMG is readily available in essentially unlimited amounts, the successful results are most fortunate.

Daily pelvic examinations with vaginal smears, fern and spinnbarkeit evaluations will determine the amount of HMG to be injected on an individual basis. It appears that the FSH-LH ratio of 70 IU-20 IU is the most desirable with a total dose of 1260 IU of FSH and 360 IU of LH, and 10,000 IU of HCG.

Five patients received batch #2225 (FSH-80 IU and LH 25 IU) which had the strongest ratio. Enlarged cystic ovaries with ascites developed in two, one severe and one mild. When a severe reaction occurs, gonadotropins should be discontinued immediately. The rapid ovarian enlarge-

TABLE 1.—DOSAGE SCHEDULE

PATIENT	NO. OF COURSES	BATCH	DOSE OF HMG	TOTAL FSH ACTIVITY	TOTAL LH ACTIVITY	DOSE OF HCG	TOTAL HCG ACTIVITY
1	1	2138	2 x 9	1260 IU	360 IU	5000 IU x (12-13)	10,000 IU
2	1	2138	2 x 9	1260 IU	360 IU	5000 IU x (12-13)	10,000 IU
3	1	2138	2 x 9	1260 IU	360 IU	5000 IU x (12-13)	10,000 IU
4	1	2138	2 x 9	1260 IU	360 IU	5000 IU x (12-13)	10,000 IU
5	1	2138	2 x 8	1120 IU	320 IU	5000 IU x (12)	5,000 IU
6	1	2138	1 x 5 2 x 2 1 x 2	770 IU	220 IU	5000 IU x (12-13)	10,000 IU
7	1	2225	2 x 9	1440 IU	450 IU	5000 IU x (12-13)	10,000 IU
8	1	2225	2 x 9	1440 IU	450 IU	5000 IU x (12-13)	10,000 IU
9	1	2225	2 x 9	1440 IU	450 IU	5000 IU x (12)	5,000 IU
10	1	2225	2 x 5 1 x 4	1120 IU	350 IU	5000 IU x (12-13)	10,000 IU
11	2	2225	2 x 5 1 x 4	1120 IU	350 IU	5000 IU x (12-13)	10,000 IU
		2282	2 x 5 1 x 2	900 IU	300 IU	5000 IU x (12-13)	10,000 IU
12	2	2282	2 x 6 1 x 2	1050 IU	350 IU	5000 IU x (12-13)	10,000 IU
		2282	2 x 6 1 x 3	1125 IU	375 IU	5000 IU x (12-13)	10,000 IU
13	1	2282	2 x 8 1 x 1	1275 IU	425 IU	5000 IU x (12-13)	10,000 IU
14	1	2282	2 x 7 1 x 2	1200 IU	400 IU	5000 IU x (12-13)	10,000 IU
15	1	2282	2 x 9	1350 IU	450 IU	5000 IU x (12-13)	10,000 IU
16	1	2282	2 x 9	1350 IU	450 IU	5000 IU x (12-13)	10,000 IU
17	1	2282	2 x 8 1 x 1	1275 IU	425 IU	5000 IU x (12-13)	10,000 IU
18	1	2282	2 x 7 1 x 2	1200 IU	400 IU	5000 IU x (12-13)	10,000 IU

Batch # 2138 (FSH-70 IU—LH 20 IU). Batch # 2225 (FSH-80 IU—LH 25 IU)
Batch # 2282 (FSH-75 IU—LH 25 IU). HCG contained 5000 IU per ampule.

The dose of HMG is given in numbers of ampules per day and the number of days of treatment (e.g., 2 x 9 = 2 ampules daily for 9 days). Dose of HCG is given in International Units, the figures in parentheses refer to days of HCG treatment, (e.g., 5000 x (12-13) = 5000 IU from day 12 to day 13).

Table 2.—Clinical Results.

Patient	Age	Marital	Semen Analysis	Proof of Ovulation	Pregnancy	Remarks
1	30	1½ yr.	30 Mil.	T,M,S		Rx started 11/21/66, menses started 12/12/66.
2	21	1½ yr.	40 Mil.	T,M,S	P	Rx started 12/17/66, positive A-Z 1/25/67. Delivered normal female 7 lbs. 1 oz.
3	28	2 yr.	190 Mil.	T,M,S	P P	Rx started 1/23/67, menses 2/17/67. 3/30/67, 5/2/67, positive A-Z 6/19/67, aborted 7/26/67. Became pregnant again with positive A-Z 2/8/68, delivered normal male 10/9/68, 8 lbs.
4	24	3 yr.	150 Mil.	T,M,S		Rx started 1/29/67, menses 2/25/67.
5	23	6 yr.	140 Mil.	T,M,S		Rx started 3/13/67, menses 4/8/67. Due to lack of drug, patient given 3 courses of Clomiphene therapy. 5/19/67—1 x 5 starting day 5 8/12/67—1 x 5 " " " 9/10/67—1 x 5 positive A-Z 10/26/67, delivered 6/22/68 normal male, 8 lbs. 2 oz.
6	24	3½ yr.	10 Mil. to 40 Mil.	T,M,S	P	Rx started 3/22/67, menses 4/15/67. This patient ovulated with the smallest dose of HMG. Husband was given 2 courses of HCG over 4 months with improvement in motility and count. Patient had almost regular menses following HMG, had positive A-Z 10/10/67, but aborted 1/16/68.
7	35	5½ yr.	150 Mil.	T,M,S	P	This patient developed large ovarian cysts with ascites following completion of HMG-HCG therapy. Rx started 4/28/67. Was hospitalized for 6 weeks. Had 1 positive A-Z, and 2 negative A-Z tests, while in hospital, but patient was pregnant and delivered 2/18/68 normal female, 6 lbs. 2 oz.
8	33	15 yr.	109 Mil.	T,M,S		Rx started 4/21/67, menses 5/14/67. This patient had poor p-c tests throughout.
9	23	3½ yr.	150 Mil.	T,M,S		Rx started 4/30/67, menses 5/25/67. Patient developed slightly enlarged ovaries with mild abdominal distention, was hospitalized for 5 days with normal ovaries after menses started.
10	22	14½ yr.	100 Mil.	T,M,S	P P P	Rx started 5/12/67, positive A-Z 6/22/67. Had a premature female 11/23/67 who lived 22 hours. Patient became pregnant twice since and now has 2 normal children.
11	25	3 yr.	50 Mil.	T,M,S		Rx started 10/14/67, menses 11/10/67.

12	24	3½ yr.	10 Mil. to 30 Mil.	T,M,S	Rx started 5/24/68, menses 6/17/68. This patient had another course of treatment 11/26/68, menses 12/20/68. Husbands count varied from 10 Mil. to 30 Mil. with four semen analysis.
13	34	13 yr.	150 Mil.	T,M,S P	Rx started 2/3/68, menses 2/28/68 and 4/14/68. Positive A-Z 5/31/69. Delivered normal male 1/24/69, 6 lbs. 5 oz. (This patient became pregnant after second normal menstrual period).
14	28	8 yr.	50 Mil.	T,M,S P	Rx started 6/17/68, positive A-Z 8/6/68. Delivered premature twins 1/13/69, male 2 lbs. 12 oz., 1/14/69 female 2 lbs. 10 oz. Both children are living and well.
15	24	4 yr.	120 Mil.	A	Rx started 3/21/69, menses 5/7/69. This patient had a monophasic BBT chart and poor spinnbarkheit tests. She had excelled ferning and p-c tests, with vaginal spotting 4/1/69 and 4/2/69. She was classified as anovulatory.
16	26	3½ yr.	77 Mil.	T,M,S P	Rx started 4/9/69, positive A-Z 5/14/69, 1/22/70 boy, 8 lbs. 4 oz.
17	27	3 yr.	200 Mil.	T,M,S P	Rx started 4/13/69, positive A-Z 5/19/69. X-ray revealed twins. 1 boy, 6 lbs. 3 oz. Delivered 1/20/70, macerated male infant.
18	33	9 yr.	140 Mil.	T,M,S	Rx started 4/17/69, menses 5/12/69.

Proof of ovulation has been abbreviated as follows:
T = shift in BBT.
M = change in mucus from fern-formation pattern to cellular pattern.
S = change in vaginal smear compatible with progesterone secretion.
P = pregnancy.
A = Anovulatory.[10]

ment with pain and ascites is known as the hyperstimulation syndrome. Watchful waiting is the course of therapy together with intravenous fluids to replace loss in the peritoneal cavity. Surgery would be indicated only if there is shock due to rupture of the cyst with hemoperitoneum.

A few patients did complain of some mild uncomfortable feelings in the pelvis at times during the treatment, but did not have ovarian enlargement nor was the pain consistent.

Eight patients in the group who conceived with HMG-HCG are again having irregular menses with periods of amenorrhea and apparent anovulation.

Encouraging results have been reported for patients with polycystic ovaries who have failed to respond to wedge resection. The administration of HMG has also proven a useful test of ovarian capacity to respond to gonadotropins when primary to secondary amenorrhea rather than infertility is the present complaint, and where pregnancy is not the immediate objective.

Patients with primary ovarian failure and elevated urinary gonadotropins may be expected not to respond to exogenous gonadotropins, nor would those whose infertility is not due to failure of ovulation. All patients should therefore be thoroughly screened by appropriate diagnostic procedures to eliminate endocrinopathies, developmental anomalies of the genitourinary tract or pelvic inflammatory disease as etiologic factors in their infertility.

Conclusions

HMG is a useful agent for treatment of the infertile woman in whom anovulation has been documented as the basis for infertility. This includes certain patients with primary or secondary amenorrhea, oligomenorrhea and those with anovulatory menstrual cycles. Thus, many women with secondary ovarian failure or normal or low urinary gonadotropins may be considered potential candidates.

HMG is administered intramuscularly, alone or in conjunction with human chorionic gonadotropin. The exact dose varies from patient to patient and in the same patient at different times. It is, therefore, suggested that overdosage be avoided by continuous monitoring of response in each patient.

Change in the maturation index of the exfoliated cells from the vagina, in the quality and quantity of the cervical mucus or in the histologic appearance of an endometrial biopsy specimen may serve as indicators of increased estrogen secretion. This is further documented by elevation in urinary excretion of estrogens.

Once an adequate estrogenic response is evident, human chorionic gonadotropin, 4000-6000 IU intramuscularly daily, can be given either combined or sequentially with HMG to induce ovulatory or progestational response. If ovulation ensues, a shift in these indices is characteristic of progestogen production. Elevated pregnandiol excretion provides further evidence for increased luteal function.

Local inflammatory reactions may occur at the site of injection. Occasional pyrogenic reactions which have been observed are mild and self-limited, and usually abate with continued medication. The possibility of rapid development of ovarian enlargement with multiple follicle cysts during or after treatment warrants repeated pelvic examination. Abdominal discomfort and less frequently ascites and rupture of follicles with hemorrhage has been encountered in patients treated with similar preparations. When pregnancy ensues, multiple pregnancies, early spontaneous abortions and premature delivery can occur with normal frequency, although improved methods for determining optimal dosages have lessened their complications.

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Anti-Substitution Laws

Efforts to repeal anti-substitution laws have been stymied wherever attempted this year. In 1970 the American Pharmaceutical Association voted to embark on a state-by-state campaign to repeal existing laws. Last year Massachusetts adopted a bill that permits substitution of therapeutically equivalent drugs but so far in 1971, although bills seeking repeal have been introduced in at least 12 states, none have been enacted. Alaska and Missouri, the only two states previously not having anti-substitution laws, this year enacted measures making blanket drug substitution illegal. The AMA has opposed measures that would permit blanket substitution of drugs by pharmacists on the grounds that medical considerations should determine when a physician may delegate the choice of source or brand of prescription drugs. It has assisted state medical associations in their efforts to maintain anti-substitution laws. The APHA is expected to intensify its repeal efforts in selected states this year.

Research Toward Improved Psychiatric Care

Barbara A. Kay, Ph.D., Robert L. Williams, M.D.,
and Richard E. Gordon, M.D., Ph.D.

The Department of Psychiatry at the University of Florida College of Medicine provides an educational program combined with patient care and conducts research to support these objectives. The quality and quantity of professional publications is one index of research effort. During the last three years six books, more than a hundred articles and ten chapters in books have been published by faculty members who must of necessity give priority to teaching and service in a clinical department.

Since its inception in 1958 the Department has sought to improve psychiatric care through research. Several areas have received major emphasis.

An Interdisciplinary Approach to the Study of Behavior

The Department of Psychiatry incorporates a Division of Behavioral Sciences which provides a relationship of major importance in facilitating an interdisciplinary approach to the study of behavior. The sharing of faculty from anthropology, ethology, neurophysiology, social psychology and sociology has resulted in a number of collaborative research efforts.

In the Comparative Behavior Laboratories directed by Sol Kramer, Ph.D., Professor of Biological Sciences in Psychiatry, ethological research into mating and maternal behavior and the influence of fixed motor patterns upon character formation has been undertaken. An important activity of the Division has been development of the Multiphasic Screening Center by Richard E. Gordon, M.D., Ph.D., Associate Professor and head of the Division, in collaboration with Mario Ariet, Ph.D., Associate Professor of Industrial and Systems Engineering; Ewen M. Clark, M.D., University Physician, and John I. Thornby, Ph.D., Assistant Professor of Statistics; state and national agencies and numerous colleagues in the University. The Center is an automated health testing and data storage and retrieval facility which accepts referrals of patients for health evaluations. A report of findings is promptly returned to the referring physician for more efficient delivery of medical care by him.

Five Year Social Psychiatric Research Project

John J. Schwab, M.D., is the principal investigator on a five year National Institute of Mental Health grant designed to develop a paradigm for assessing the prevalence of mental illness, to ascertain the utilization and nonutilization patterns of health care, and to establish the social and cultural variables correlated with emotional impairment. This project was started in 1969 in Alachua County. George J. Warheit, Ph.D., is director and Gary Spencer, Ph.D., assistant. Both are sociologists jointly appointed in the Departments of Sociology and Psychiatry.

The purpose of the study is to develop a model which can be utilized to evaluate mental health needs and services. This work involves testing associations between mental impairment and both contributing and caretaking factors at three levels —individual, family and community.

Sleep Laboratories

Robert L. Williams, M.D., Professor and Chairman of the Department, and Ismet Karacan, M.D., D.Sc., Professor and Director of the Sleep Laboratories, have published numerous articles regarding the relationships between specific sleep disturbances and clinical symptoms and their diagnoses. In addition to conducting long-range studies establishing the normal sleep patterns, numerous studies have been conducted to determine the

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changes in sleep patterns peculiar to certain normal and abnormal conditions.

A multidisciplinary study of pregnancy and the postpartum period is built around changes in sleep patterns and the concomitant changes in hormone secretion, psychological and social factors. Dr. Karacan is principal investigator.

A study of the relationship between the release of the human growth hormone as a function of changes in electroencephalographic wave forms during sleep is being conducted by Dr. Karacan; Arlan Rosenbloom, M.D., Assistant Professor of Pediatrics, and Javier H. Londono, M.D., Assistant Professor of Medicine.

The sleep patterns of dialysis patients have recently been subjected to intensive study by Dr. Karacan; George Bose, M.D., and Samuel R. Warson, M.D.

A long-range normative study of the characteristics of nocturnal penile tumescence across age groups from infancy to old age is almost completed. This study was directed by Dr. Karacan assisted by Carolyn Hursch, Ph.D., psychologist. The normative data are now being used for comparison with further studies of this phenomenon in various pathological conditions.

An intensive study of insomnia is being pursued under the direction of Dr. Karacan; Dr. Hursch, and Patricia Salis, B.A., psychologist.

In cooperation with the College of Engineering, Dr. Karacan and Jack Smith, Ph.D., Professor of Engineering, and a group of engineering graduate students are developing advanced techniques and equipment for recording and analyzing the enormous amount of data which result from lengthy all night recordings of sleep brain waves for large numbers of research subjects.

Paul L. Adams, M.D., Professor of Psychiatry and Pediatrics, and Chief of the Division of Child Psychiatry, has been responsible for extensive research on all phases of child psychiatry and related subjects such as obsession, poverty and the life cycle, objective behavior patterns in psychotic children and fatherlessness.

Joel M. Stein, M.D., Assistant Professor of Psychiatry and Pediatrics, is studying the relationship between maternal deprivation and growth retardation. Harvey L. Langee, M.D., Assistant Professor of Psychiatry and a former professional film writer, has prepared scripts for motion pictures during the past year in the area of alcoholism and crisis intervention.

Other Research Studies

The collaboration of the faculty from psychiatry, psychology, occupational therapy, recreation and social work with the faculty from the disciplines represented in the Department of Psychiatry has had significant impact upon quality and quantity of research outcome. Most of the faculty and clinical staff are involved in some aspect of basic and/or applied research. These examples indicate the range and diversity of research activity and published reports.

Paul L. Adams and Nancy McDonald, M.S.W., have presented their findings on "School Phobia and Bisexual Conflict." "Motoric Therapy," a technique of unleashing hostility, is being refined by George W. Barnard, M.D. "Resocialization of Autistic Children" is being pursued by a team of child psychiatry researchers headed by Dorothy E. Collins, M.S.W. Arthur L. Fabrick, M.S.W.; William C. Ruffin Jr., M.D., Professor of Psychiatry, and Sidney B. Denman, Ph.D., Associate Professor of Sociology in Psychiatry, have completed a comprehensive analysis of the "Characteristics of Patients Discharged from Psychiatric Inpatient Service." "Shadow Therapy," a technique employed to uncover the meaning of imagery to children, has been developed and used successfully by Mary F. Robertson, M.D. Charles J. Vierck Jr., Ph.D., has reported on his sophisticated research into "Reticular Stimulation and Generalized Drive." Independently, both Michael J. Kehoe, M.D., and Dr. Ruffin have reported on their active involvement in "Psychiatric Re-education of General Practitioners." Arthur E. Larson, M.D., founded the "Drug Store in the Middle of the Block" as part of his work with drug users at the Student Mental Health Center, and Bertha M. Most, M.D., has presented data from her study of the "Traumatic Effects of Hospitalization for Renal Biopsy Upon Young Children."

Gustave Newman, M.D., and Sidney B. Denman, Ph.D., have investigated data obtained in psychiatric evaluations performed for the courts. A significant percentage of felons report the early loss of their father or lack of a father in the home where they were boys.

A file of reprints is available in the Department of Psychiatry Library, University of Florida College of Medicine, and a bibliography is available from Dr. Williams.

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Lysergic Acid Diethylamide and Chromosome Damage

Its Controversy

Charles H. Carter, M.D., Donald G. Carpenter, M.S., and Josephine M. Connolly, M.T.

There is growing concern in the medical profession over abuse of the hallucinatory drugs by young people. Aside from the immediate psychosocial problems generated by their abuse, this concern is centered upon the moral, mental and physical degeneration that often follows. Excessive exposure to many chemical or physical agents has been associated with genetic damage and investigations into abused drugs, primarily LSD, have yielded results that are uncertain and controversial.

In vitro studies of peripheral leucocyte cultures treated with varying concentrations of LSD over a wide range of exposure times usually showed chromosome damage that was reflected by increased numbers of breaks, gaps, dicentric quadriradial and Ph_1 (Philadelphia-like) chromosomes.[1-4] A report has been made,[5] however, of failure to induce damage after the addition of LSD to Chinese hamster leucocyte cultures. Although the majority of studies have demonstrated chromosome damage, caution should be exercised in drawing any conclusions as to the in vivo effects of the drug because of difficulties in matching in vivo concentrations, exposure times and the effects of the drug metabolites.

Chromosome Changes

The main body of controversy involves the question as to whether or not LSD administered in vivo causes chromosome alterations in human subjects. Careful studies by several workers[1,6-9] have demonstrated changes, while investigations by others[10-13] failed to show significant differences between LSD users and controls. These disparities leave us in a quandary.

Examination of these studies point out some factors that may contribute to these differences. A variety of widely used drugs and physical agents have been implicated in chromosome damage changes. Acetylsalicylic acid (aspirin), caffeine, several antibiotics, tranquilizers, cyclamates, pesticides, viruses and ionizing radiation, in sufficient dosage, are known to be clastogenic. It is impossible to exclude these as contributory factors in either control or study subjects in an investigation of any agent, including LSD, and its effect on human chromosomes.

The literature contains many implications about restitution of chromosome breaks, although little is known about the time required for these repairs to be effected. Studies report increased breaks in a patient 22 years after therapeutic dermal x-ray treatment[6] and up to three years[14] after LSD exposure. We are forced to conclude that it is extremely difficult to find valid control or test subjects due to the work variety of agents that are known to be clastogens and the uncertainty of time required for chromosome repair after exposure to them. It is probable that restitution time is related to the rate of cell division in different tissues, making any generalization difficult.

Almost without exception, LSD users admit

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to using a wide variety of other hallucinogens, opiates or other drugs whose effects on chromosomes have not been adequately studied. Commonly available LSD contains several contaminents that could be clastogenic. Chromosome damage, if found in these patients, cannot be attributed solely to LSD with certainty.

Several syndromes are associated with chromosomal anomalies similar to those reported in LSD users. Reports have been made of chromosomes resembling the Ph_1 type,[6,7] a deleted G-group autosome associated with chronic myelogenous leukemia. Increased chromosome breakage is seen in ataxia telangiectasia, Bloom's syndrome and Fanconi's anemia, which are autorecessively inherited. Neoplastic diseases and leukemia have been associated with similar chromosome damage, although an increase in their incidence in LSD users has not been substantiated.

If damage is really induced in somatic cells following LSD exposure, the question arises as to whether or not meiotic chromosome damage also occurs. Answers have been sought in studies of mouse spermatogonia. Abnormalities were reported by Shakkebaek, et al[15] although the differences between LSD treated and control animals were not pronounced, and no statistical testing was done. Cohen and Mukherjee[13] found a ten-fold increase in mitotic and meiotic chromosome anomalies in a study of mouse marrow and spermatogonial cells after LSD treatment. They also concluded that the somatic cells from the bone marrow were more susceptible to damage than spermatogonia. The implications made by these authors from these findings were that this chromosome damage might lead to loss of fertility, fetal wastage and congenital anomalies. Caution must be used in inference of similar findings in humans.

Effect in Pregnancies

The final judgment of LSD and its damage to human genetic apparatus will be made only after examination of several generations of offspring of well documented cases of LSD use. Studies of the outcome of pregnancies when one or both parents have been exposed to LSD prior to conception suggest that such use was detrimental to the outcome. It has been reported that the miscarriage and abortion rate is high in pregnancies in which one or both parents have used the drug before conception.[16]

The final question that must be considered in this discussion is the possible teratogenicity of the drugs after in utero exposure. Several investigators have reported animal studies using mice in which there were substantially increased numbers of stunted stillborn and congenitally abnormal offspring.[17,18] Geber[19] reported teratogenic effects in hamsters. Others[20,21] have reported a lack of teratogenicity in rats and other species.

A few studies have been published on the outcome of human pregnancy after in utero LSD exposure. One case each of congenital limb malformation has been reported by Zellweger et al[22] and Hecht et al.[23] Cohen et al[8] reporting on nine pregnancies and Hulten et al[24] and Warren et al[14] each reporting on one case found no evidence of the teratogenic action of LSD. In none of these reports were the samples of sufficient size to warrant the drawing of any conclusion.

In the author's laboratory, using conventional techniques, a study was done of 20 patients who had ingested LSD plus other drugs at least once. These were all young people between the ages of 14 and 22 years who, in almost every case, admitted to having used marijuana, heroin, amphetamine or barbituates in addition to LSD. Although no large scale controlled study with statistical evaluation was made, numerous breaks, both chromatid and isochromatid, gaps, distortions, centromere separations, dicentrics or chromosome fragments were found. In 15 patients, the effects could be termed severe with five showing definite but lighter damage.

One of the females and her husband had taken LSD before and during her pregnancy. She delivered an apparently normal infant at term. Examination of the child's chromosomes showed many abnormalities similar to those seen in adult users. Another of the females who had taken both LSD and amphetamines 16 months before conception and smoked marijuana during pregnancy, spontaneously aborted at two months gestation. An infant of six months, whose mother had used LSD while living in a "hippie commune," was brought in for examination. The child appeared normal except for a slight macrocephaly and moderate atonia. Chromosome studies showed multiple aberrations.

Two children have been admitted to this hospital whose parents admitted use of LSD and other drugs early in pregnancy. One child had a severe exencephaly and the other a midfacial cleft. However, many patients have been admitted with both syndromes with no history of LSD exposure.

Conclusions

The controversy over detrimental effects of LSD on the genetic process still continues. Many obstacles to controlled investigations leading to answers to this question exist. Technical procedures for chromosome preparation and examination need improving in order that intact cells may be examined in vivo to assure us that we are not observing artifacts. Purity of LSD taken by abusers must be questioned and exposure to other drugs, chemical and/or physical agents over a period of time, that has yet to be determined, must all be considered as a possible causative or contributing agent in human subjects. The dangers of using pure LSD-25 on human subjects, without medical or psychological justification, also precludes to a large extent its use in controlled genetic studies. Substitution of animals, while yielding valuable results, can give us only inferences as to the effect on man. In the final analysis, when all of the mitotic and meiotic chromosome studies have been made, proof will be found only in the careful study and documentation of several generations of offspring of many LSD exposed persons.

In the meantime, enough evidence has accumulated to cast suspicions upon this and similar drugs as being possibly detrimental to the human genetic apparatus, giving us enough justification to warn potential users of the possible dangers of LSD use.

References are available from the authors upon request.

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Government Medicine As My Office Girl Sees It

A plea about our Florida Medicaid. There is such a lack of understanding on the recipients' part that it is pitiful. Each patient who is issued a card with the family and member numbers feels that he is fully covered. It seems that in issuing these cards the case workers do not inform the people of its limitation. So, if a doctor does accept these patients in good faith, and they do not understand that only a part of the doctor's fee is payable, if at all, he is working for the pleasure of it.

Besides the frustration of the patients, the doctor and his office are put to no end of detail with provider number, transaction numbers, over 65 patients, under 65 patients, etc., which is costing him time and money. Not to mention paper work and time with the sick people.

I don't know how other states are making out but it seems from my experience Florida's is not at all workable. It is no wonder that most of the physicians do not accept Medicaid patients, leaving them to wander around and suffer doubt and frustration while seeking aid for their physical ills.

It appears that the administration of the program, the local offices with their employees and computers are the only ones benefiting from the program while the so-called recipients and the physicians are left holding the bag.

J. Braden Quicksall, M.D., Editor
St. Petersburg

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The Nasolabial Flap in Reconstruction of the Nose

J. A. Burnam, M.D.

"Man's face is his single most distinguishing characteristic. It is at once the key to his identity and his primary means of communicating both thought and emotion. Acknowledging these important functions of the face, modern society has come to place a premium on its preservation."[1] The nose, in turn, is the most prominent characteristic of the face and is a key area for both function and appearance.

The nose is important not only for facial contour, but also is vital as an airway, for humidification, olfaction, voice resonance and for drainage of the sinuses and tear ducts.

Reconstruction of a nasal defect, whether surgical or traumatic, is a difficult problem dealing with a complex structure. Function and tissue restoration must be considered; also color match and three dimensional contour. The skin of the lower portion is intimately attached to the upper and lower lateral cartilages. Thus, a lesion in this area may often involve full-thickness defects because of cartilaginous involvement. The skin of the upper nose, in contrast, is rather loose and can often be closed by direct approximation. Local flaps are required in defects involving skin and perichondrium or periosteum. Flaps are also very often needed for repair postirradiation because of the poor vascularity.

The support of the nose represents another set of interesting problems, i.e., preparation of the bed for an appropriate graft and selection of the correct graft, whether for tip support or elevation of the dorsum.

Probably the best single material for repair of a saddle nose deformity is nasal septal bone or cartilage.[2] Vomer, ethmoid plate and quadrangular cartilage all are easily accessible. In cases where the defect is so large or where septal structures are not available, iliac bone graft is most useful. The technique for obtaining iliac grafts was well described by Anlyan and Manis.[3] Some success has also been achieved with silicone prosthesis for small defects.[4]

In selecting flaps, it is very important to use tissue of good color match and texture. No other area of the body can provide skin coverage to the face and nose which equals that from the face itself.[5] It is important, too, not to put the patient through a long series of operative procedures which are time-consuming and costly. For these reasons, the local regional flap is used by most surgeons for reconstruction of the nose. For very large nasal deformatives, tissue is most available from the forehead,[6] but in moderate to small defects, the nasolabial flap is indispensable.

The nasolabial flap is one of the most useful and versatile rotation flaps. It has multiple possibilities in reconstructive procedures of the nose, cheek, lower eyelid, and upper lip. The nasolabial tunnel flap has also been described for defects of the anterior palate, septum, columella and upper lip.[7] This flap achieves the basic requirements of a tissue graft, i.e., excellent color match and contour. It also has superior vascularity and good mobility. Usually it can be used in a one-stage operation and, very importantly, leaves little or no donor site defect or scar. Its most prevalent use has been in reconstruction of small to moderate sized defects of the alar rim; however, others have described use of composite grafts from the ear with good success.

Lining of larger flaps is obligatory, especially if one contemplates the use of a bony or cartilaginous graft for dorsal support and contour. The lining can be achieved by several methods: split-thickness skin, regional flap or by free septal mucosa. In smaller defects, the nasal mucosa will reline the flap in an adequate way.

This paper is written to amplify the possibili-

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Figure 1

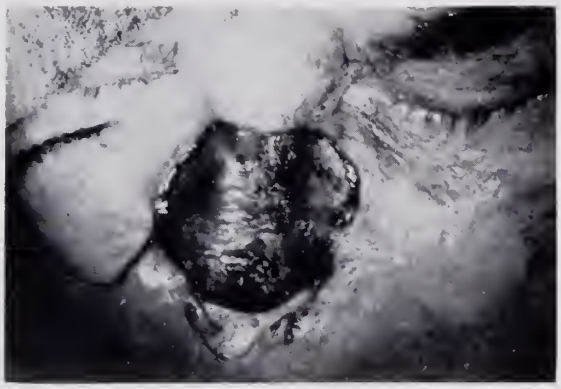


Figure 3



Figure 4



Figure 2

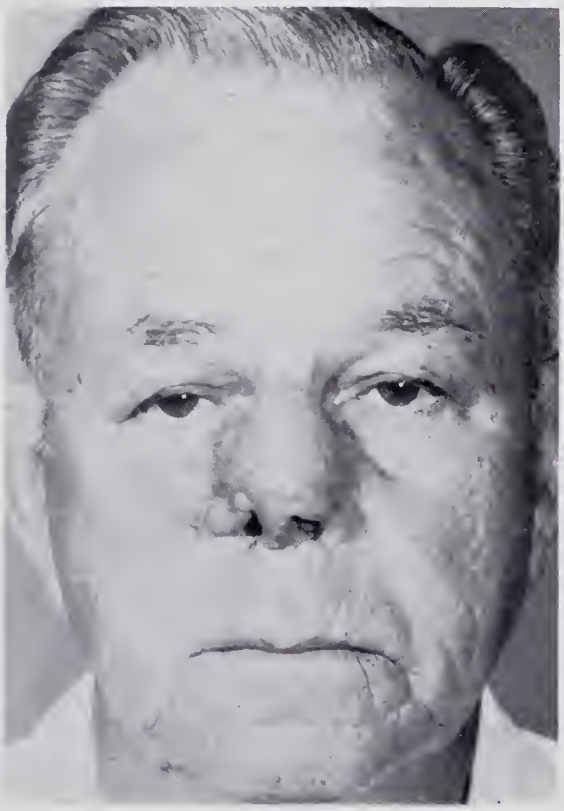


Figure 5



Figure 6

ties of the nasolabial flap, in moderate sized as well as small defects. The following case exemplifies our experience.

Case Report

A 62-year-old white male underwent dermabrasion of the nose for rhinophyma in September 1969. Postoperatively the patient suffered from infection of the operative site and secondary chondritis with resulting dissolution of the lower lateral cartilages and severe scar contracture of the nose. When first seen by our service, he appeared as shown in Figures 1 and 2. Resection of the scar and release of the remaining nasal tip was done, preserving the mucosal lining of the nose as shown in Figure 3. The nasolabial flap was developed and sewn into place (Fig. 4). The results three months past surgery are shown in Figures 5 and 6.

Summary

Adherence to good surgical principles of reconstructive surgery is necessary in any procedure of the nose or face.

Full thickness grafts can be used in small cutaneous defects.

Regional flaps are necessary in larger defects, the nasolabial and forehead being most useful.

Lining is necessary in larger defects or when a bone graft is anticipated.

The nasolabial flap is probably the most useful of flaps for nasal surgery as it completes the necessary requirements of a good contour and color match and minimal donor site defect.

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Benign Villous Tumor of the Duodenum

Peter J. Palmisano, M.D. and Francis P. Guzzo, M.D.

Villous tumors of the upper GI tract are exceedingly rare, whereas their occurrence in the colon is well known. This report presents a case of benign villous tumor of the duodenum and emphasizes the similarity in appearance but dissimilarity of symptomatology between colonic and upper gastrointestinal villous tumors.

Case Report

The 52-year-old white man was admitted with a ten-year history of hypertension and a 1½ year history of angina pectoris. There had been no weight loss or symptoms referable to the GI tract such as nausea, abdominal pain, melena, or evident rectal bleeding.

System review and past history were entirely negative except for the cardiovascular disease.

Physical examination revealed a well-developed, ruddy complexioned man in no acute or chronic distress. The only positive physical findings were an enlarged prostate and a blood pressure of 170/90. There were no palpable abdominal masses or organopathy.

All laboratory studies were unremarkable and revealed no anemia or occult blood in the stool. The only positive radiographic finding was a 3.5 cm. x 8.0 cm. expanding lobulated tumor in the third and fourth portions of the duodenum. Included in the differential diagnosis of this lesion was lymphoma, adenocarcinoma, villous tumor, and other lesions of mesenchymal origin.

At surgery a soft friable tumor was excised and reported by both frozen and permanent section to be a totally benign villous tumor.

Discussion

In cases of colonic and rectal villous tumors a definite clinical syndrome has frequently been recognized by excessive mucoid diarrhea, blood in stool, and severe electrolyte depletion, especially sodium and potassium.[1-2] As with colonic villous tumors, their propensity for malignant change has been documented.[3-4] Villous tumors occurring in



Figure 1

the upper gastrointestinal tract have symptomatology varying from massive GI bleeding,[5] anemia and weight loss[6] to being totally asymptomatic as was apparent in this case. The villous tumors presenting with symptomatology in the upper GI tract in general have been malignant.[7]

The radiographic appearance of villous tumors of the gastrointestinal tract are the same regardless of location as far as we have been able to ascertain. The pertinent radiologic findings consist of a broad-based, pliable, polypoid lesion frequently producing a soap bubble or "frond-like" appearance.

This appearance was present in our case (Fig. 1) and in all reported cases occurring in the upper gastrointestinal tract.[3,6]

Another case of totally benign villous tumor of the duodenum is reported. Its rarity, radiographic similarity to colonic villous tumors, and clinical symptomatology has been mentioned.

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New Federal Drug Regulations Now In Effect

Considerable confusion has resulted by the simultaneous implementation of new federal and state drug regulations. In an attempt to clarify who needs federal and state drug licenses, meetings have been held with federal and state officials. As of this writing, FEDERAL REGULATIONS require physicians to obtain a license to write prescriptions, administer or dispense Controlled Substances in the following five defined schedules:

Schedule I Substances are drugs that have no accepted medical use in the United States. Some examples are heroin, marijuana, LSD, peyote, mescaline, morphine methylsulfonate, etc.

Schedule II Substances are drugs with a high abuse potential with severe psychic or physical dependence liability. Most Schedule II Substances have been known in the past as "Class A narcotic drugs." One non-narcotic substance is in this group—liquid injectable methamphetamine. Examples of drugs in this category are opium, morphine, codeine, methadone, etc.

Schedule III Substances have an abuse potential less than those in Schedules I & II and include drugs formerly known as "Class B narcotics," some non-narcotic drugs such as amphetamines, Ritalin, some tranquilizers, and barbiturates (except phenobarbital, methyl-phenobarbital and barbital). Paregoric is now listed in this schedule.

Schedule IV Substances include such drugs as barbital, phenobarbital, meprobamate, Librium and Valium.

Schedule V Substances were preparations known as "exempt narcotics" with the exception of paregoric which is now a Schedule III Substance.

Your Bureau of Narcotics and Dangerous Drugs registration number must appear on all orders and prescriptions for controlled substances. This number replaces your old IRS and FDA numbers. Physicians who held IRS Narcotic Licenses were automatically sent applications for the new BNDD license. Those physicians who previously had not had narcotic licenses and prescribed drugs such as those listed in Schedules III, IV and V must now obtain a BNDD license. Physicians who have not received an application for a federal license may obtain one by writing the Bureau of Narcotics and Dangerous Drugs, 546 Carondelet St., New Orleans 70130. Please be sure to carefully read the instructions accompanying the application—especially the inventory requirements.

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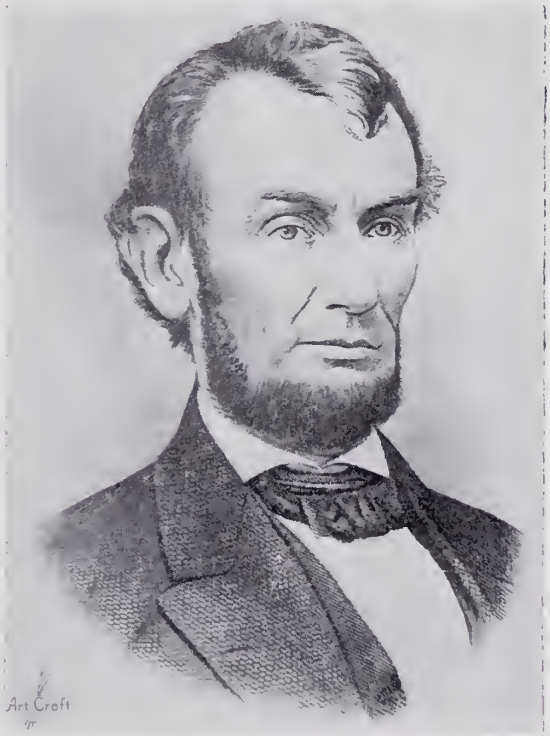
Essays on Lincoln

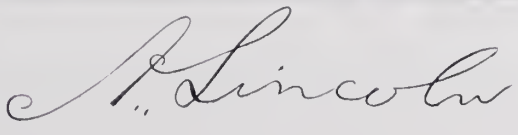
I. Leo Fishbein, M.D.

History has a way of separating the banal from the important facets of our lives; yet, history often teaches us nothing except that we have made the same mistakes for centuries. Many legends and myths have accumulated about Abraham Lincoln since his assassination on April 14, 1865, and his death the following morning. Perhaps these essays may better help us to understand the man and the times.

Lincoln was Father of his country and oedipal forces were at work to belittle, harass and even destroy the symbol of authority. Many attempts were made upon his life while he was president and the dark abysses of sick minds constantly fomented hatred, dissension and terror among our people. They again brought shame and sorrow to our nation in the recent dastardly assassination of President John F. Kennedy on November 22, 1963.

Abraham Lincoln sought to be a good president in a period of tumult and confusion and he feared neither time nor death. He was guided to greatness. He pursued perfection with the hope that he might use his God-given qualities to transcend himself, offering his attributes and values to the American people; knowing full well he might thereby jeopardize his life because of these high standards of morality, justice, honor and dignity. He had conquered poverty and a deficient education and had felt the barks of a critical society. He sought equitable distribution of socio-economic forces for improvement of the Negro and the poor classes. He was a simple man with the inner conviction to dedicate his life to his people and his country without guile, fortune or profit. He was beholden to no man or party and his innate generosity, ingenuity and idealism gave him the courage to make decisions that he felt were right for himself, for others and for the country he loved. His enthusiasm, his common touch, his protective wit and humor in times of crises—all enabled him





to build a great land that stood for Liberty and Justice. He was and always will remain the eternal symbol of America's greatest heroic man who taught us humility, truth and compassion in life as in death. "There lies a man for the ages."

The Cooper Union speech Lincoln made on February 27, 1860 made him presidential timber overnight. The great hall of Cooper Institute in New York City was full of politicians and plain people who were waiting to hear what the tall lanky man from Illinois had to say about the controversial subject of slavery. The slave trade from the African continent was disturbing the conscience of every God-fearing person in the North and South and cries were heard to abolish this practice. There was to be trouble ahead, for this would mean a loss of revenue for most southern plantation owners. This speech was to cast shadows for a century; to cause hatred and resentment for another hundred years.

Abraham Lincoln, in his simple yet awkward manner, started out slowly, apologizing for the humble truths he was about to declare. ". . . The threat of death to extort my money, and the threat of destruction to the Union to extort my vote, can scarcely be distinguished in principle." He went on to say, "The south may say leave us alone, do nothing with us and say what you please about slavery,' " yet, he declared he would not and could not be satisfied with such apathy and indifference. His voice rose to eloquence, "Neither let us be slandered from our duty by false accusations against us nor frightened from it by menaces of destruction to the government nor of dungeons to ourselves—let us have faith that right makes might; and in that faith, let us, to the end dare to do our duty as we understand it." He little realized the impact this speech would have in the future as the crowd gave him three rousing cheers. It was printed in the New York Times the next day but there was nothing else recorded about him for the next month; however, the tempers of the South were as vehement for the slave trade and profit as the North was for prohibiting it.

Soon after this, he was nominated for the presidency and his chances looked good. The common people felt they had a friend in this man who spoke their language simply with sincerity. He was not much on looks, finesse or polish but the farmers and the poor people of the city admired him greatly.

The times were dangerous, for the country was expanding westward rapidly, and there was constant talk as to what would be done with the slaves. People were just as greedy at grabbing money as in the old days of the Greeks, Romans and Egyptians and man learned little from history. Lincoln knew he would have to maintain discipline and display conviction in handling all of the country and he sincerely believed the family of the states would not dare to separate; yet he was determined to see that justice and right prevailed. His inner voice reached back through man's heritage and told him what he had to do. He maintained a serenity and equanimity for he always had the right amount of amused tolerance for the anthill politicians who thought he was a fool and could be easily manipulated.

They Laughed at Lincoln

It was simple to make fun of this big gawky, ugly duck. Anyone could tell that this man was a fool. Didn't he give money back to the people when he could have kept it and no one would have known? What nonsense, this big guy with those sincere eyes trying to be friendly with all sorts of people, even those who took him for a sucker a few times. What did he expect to learn from books that were old and seedy? What good was law in those days when the smart operators knew better how to wrap loopholes around the statutes. What a big farce, this big baboon of a man, who expected to run on a platform of honesty and justice and righteousness! What arrogance, this tortoise, who thought he could beat any hare by striving constantly in the right path to reach his goals! Lincoln surprised even himself with his own capacities to suffer indignation. This Lincoln knew victory from every defeat and he learned early in life that good would win out over evil. He forgave people their aggrandizement and hauteur. He knew their limitations and confusions; he understood people's frailties and he learned to laugh at himself and his own weaknesses as well as those of others.

Lincoln: His Own Psychiatrist

Lincoln has always been a fascinating character with his durability and invincibility. He has shattered the myths of men and shown how man can reach heights that were inconceivable. He pledged his years to the knowledge and pride and potentialities of the greats of history.

From very early years he learned from a strict father that people could be mean and yet kind; he knew what made people responsible and irrespon-

sible and he forgave them their thoughtlessness. His mother introduced him to knowledge of the world of books and men and he took these examples as constant companions in his life and sought the wisdom of history. He applied it all in his growing years with a persistence that would make monks sigh. He learned the art of detachment, studied indifference, patience, kindness, love and understanding. His experiences became experiments in living with clarity, brevity and amused tolerance. He learned early in life to think well, to interpret incidents and events that were to shape his future. He stood on the shoulders of giants from childhood and became a giant himself. He reflected deeply in a humble manner, illuminating the way with reflection from the stars to become the American Oracle, beloved by billions in every remote corner of this fascinating and querulous world.

What Made Lincoln Great

We see more and more into the depths of this man. Here was a man who came up the hard and narrow road learning from his failures and successes. He became wiser and more thoughtful about the life-role forced upon him. He kept his childlike qualities as he built a band of steel around himself, protecting himself from the childishness and hypocrisy of his day and showed little of his greatness to his contemporaries for they did not understand his wisdom and profundity. He kept unpopular thoughts mostly to himself and he used his humor adroitly as a weapon and shield with great ability and skill. He kept his emotions well hidden from the public concerning a strong love for his mother, children and Ann Rutledge. He suffered torments with his mentally sick wife, Mary Todd, and he knew how agonizing mental aberrations were. He discerned the pure virtues of wisdom and compassion and made them his own with an automaticity and perseverance that were as the air he breathed. He knew the tribulations of a nation torn asunder with hatred and civil war, knowing what it meant to have brother against brother and father against son. He pledged his own life as he proclaimed the principles of justice and human dignity and he remains one of the few men of history who reached the Mt. Everest of full maturity, preserving his childhood velvet dreams within a golden magnet.

The Day Lincoln Was Shot

The year was 1865, the day April 14th. Lincoln and his wife went to the Ford Theatre to see the play, "Our American Cousin." An actor, John Wilkes Booth, jumped into his box and fired a shot into the back of Lincoln's head. He was carried to an apartment across the street where he expired the next morning at 7:22 a.m.

Why? Booth had been brooding over this nefarious act for months. Booth had left instructions in a sealed letter with his brother-in-law concerning the dastardly deed he was about to commit, saying he would be judged not by man but by God for "a noble deed, ridding the nation of this tyrant." Life dealt Lincoln many cruel blows; this was the final one.

The New York Times, the next day, gave all the pathos of this crime. "The cortical tissue had been pushed back into the cranium and the ranking officials watched the president expire slowly." What was done to get the president the best surgical and medical care? What was the reason that the man was not given transfusions and decompression and some other radical intervention during the many hours after he was struck down by the assassin? It might have done no good, yet, it might have made some difference in the whole picture.

President Lincoln's name was preserved for posterity even before he was shot. He was the people's president, having shown in his lifetime the gentility and compassion for the simplest human being. He had hoped throughout the war that the thinking people of the South would prefer, with honor and distinction, to see right and stop the foolishness that had been brooding for 30 years which culminated in the Fort Sumter episode.

The shock of Lincoln's death was tremendous over the entire country and he was mourned by millions. He died as he lived—humbly, simply and sadly.

▶ Dr. Fishbein, 1688 Meridian Avenue, Miami Beach 33139.

The Pensacola Story

Philip B. Phillips, M.D.

Pensacola had no psychiatrists, psychiatric beds, Guidance Clinic—really no mental health effort of any sort prior to 1948. That year members of the Escambia County Medical Society determined that their patients should not have to go 210 miles to New Orleans or 360 miles to Jacksonville for evaluation and treatment. Dr. W. C. Payne Sr., president-elect of the Florida Medical Association, Dr. Sidney G. Kennedy, president of the Escambia County Medical Society, and Dr. Herbert L. Bryans, president of the Florida State Board of Health, beloved Pensacola physicians, sought the services of a young psychiatrist assigned to the Naval School of Aviation Medicine and Naval Air Training Command there. He responded willingly and began seeing patients late in the afternoon, evenings and on weekends with approval of his commanding officer and the Navy's Bureau of Medicine and Surgery.

These events initiated the cooperation of physicians, community leaders, hospital boards and administrators which has continued over more than two decades. The results have included one solution to the community's mental health problems.

A Psychiatrist and Guidance Clinic

When Baptist Hospital opened in October 1951, two rooms for psychiatric patients were made available on the medical floor. Escambia General Hospital had a small out-building, perhaps 25 feet square, where four disturbed patients could be treated if no one objected too much. When absolutely necessary, Pensacola Hospital, re-named Sacred Heart Hospital, permitted psychiatric admissions on the medical floor. In October 1952 the first civilian neuropsychiatrist began practice as a member of a group of other physicians. The local climate was not overly receptive. He was required to obtain the chief nurses' permission before his patients could be admitted and give assurance that they would not disturb the other patients.

Two years later the Child Guidance Clinic was established through efforts of parents, Junior Woman's Club, School Board and County Commissioners. A psychiatric social worker, clinical psychologist, secretary and volunteer neuropsychiatrist made up the initial staff which opened for service in the basement of a school building, later moved to an ancient frame residence and still some years later to the ground floor of the newly built county health department building.

When pressured to assume responsibility for indigent adult psychiatric patients who had no other source of care, the staff of some six professionals set up a pilot program to determine if the service was really needed. Without compensation they conducted a weekly night clinic from 1957 to 1959. It met a growing need. The staff recommended that the Clinic become the Escambia County Guidance Clinic open to all age groups; the Board of Directors concurred after studying the patient load and services rendered.

More Psychiatrists and Hospital Beds

In late 1954 a second psychiatrist entered private practice. A year later the first psychiatrist secured an associate, a former Navy flight surgeon who had recently completed psychiatric training. In 1955 the Navy doctor who initiated psychiatric consultative services at the request of Drs. Payne, Kennedy and Bryans was reassigned to Pensacola and warmly welcomed into resumption of his

This article is a condensation of Dr. Phillips' history of the care and treatment of psychiatric patients in Pensacola and the Escambia County area.

"moonlighting" practice by the three overworked psychiatrists.

The need for additional hospital beds increased with growth of the city and county. Baptist Hospital constructed the first of numerous additions in 1958 and established a 11-bed open area on the medical floor, the consensus at that time as to the best arrangement for such a service. The beautiful, four story, brick and glass Escambia General Hospital opened in 1961. One large first floor wing was reserved for the City-County Clinic, a charity service for indigents. From the standpoint of mental health needs, the greatest addition was a large first floor west wing providing an open and closed psychiatric unit totaling 30 beds.

Psychiatric beds were increased from the initial two beds in 1951 to 17 by 1958 and to 43 in 1961.

That year the two psychiatrists in group practice added a third. A Pensacola native son returned to practice solo and the Navy doctor now a Captain approaching retirement joined with a colleague to construct a building for their offices looking toward full-time civilian practice.

Experience with the psychiatric section at Escambia General Hospital convinced local psychiatrists that a separate unit offered many advantages. This became the mode for local practice. Baptist Hospital in another new addition included a 19-bed psychiatric service which was formally opened in September 1964.

The following year the Catholic Order, Daughters of Charity, which had served the community at the Sacred Heart Hospital opened the new Sacred Heart Hospital with 250 beds and a modern 17-bed psychiatric service. This increased total psychiatric beds to 79 in the three hospitals.

The 19-bed psychiatric unit at Baptist Hospital became inadequate in 1968 and the hospital purchased a convalescent home immediately across the street. Its design fitted into the rehabilitation program of the hospital and meant an instant addition of 150 beds for extended care, progressive care, rehabilitation and mental health. The entire fourth floor was modified to provide a 38-bed psychiatric unit and in 1970 the south half of the third floor was converted from extended care into an expanded mental health unit, thus adding an additional 16 beds.

The staff of the 38-bed service at Baptist Hospital is typical of those at the other hospitals. Headed by a psychiatric nurse administrator, there is additionally a clinical nurse specialist, seven regular registered nurses trained as psychiatric nurses, a psychiatric social worker, 16 licensed practical nurses, six male psychiatric attendants, mostly premedical students, a ward clerk and two relief clerks plus the usual dietary and housekeeping staff who serve the entire building.

The ground floor provides not only an admission room and offices for the administrator and nursing supervisor but adequate facilities for physical therapy and complete rehabilitation facilities for both inpatients and outpatients. On the first floor also is a large reception room, beauty shop for patients and dining room and food service department for all patients who chose to leave their floors for meals.

Mental Health Center Developed

About the time the Escambia County Guidance Clinic outgrew quarters at the health department building, the Congress passed the Community Mental Health Center Act. When state plans were called for, Florida's went in and the state was among the earliest to be approved for federal funding for construction of mental health centers.

Planning began to meet federal and state requirements for a facility at Pensacola. These included close cooperation by the three hospitals which would provide inpatient and night hospitalization, working agreements with the center staff which would provide a new Day Care Center, continued follow-up and after-care for state mental hospital returnees, expanded consultative services to the schools and Juvenile Court, and improved working relationships with Vocational Rehabilitation. These also included free exchange of records to promote continuity of care, ready access of staff to all participating units, joint in-service training programs, reciprocal consultative relationships and opportunities for research and evaluation.

In July 1968 the Escambia County Community Mental Health Center situated on a city block of property given by trustees of Baptist Hospital opened to patients. It consisted of three large one story buildings connected by passageways built with a $189,000 federal grant supplemented by $140,000 in local funds. It is currently staffed by two psychiatric nurses, six clinical psychologists, eight clinical social workers, five part-time clinical psychiatrists and one full-time psychiatrist, three educators, one full-time expert in special education, one part-time pharmacist, business administrator, part-time bookkeeper and seven secretaries.

The 1971 operating budget is slightly over $462,730. Source of this fund is roughly 30% federal, 28% state, 8% county, 13% fees, 8% United Fund, 6% School Board, and 7% other sources. The budget includes a $30,000 grant received from the Law Enforcement Planning Council to amplify a drug abuse program for youngsters. Recently the Northwest Florida Alcoholic Rehabilitation Clinic was absorbed into the Center.

Analysis of activities of the Center for the first eight months of 1970 reveals that an expenditure of $208,623 for salaries, utilities, supplies and depreciation provided 12,599 hours of direct treatment and consultation at a cost per hour of $15.34. This does not include several thousand hours of round-the-clock crisis calls or some 1,300 hours of professional time on calls to parents, schools and agencies, or the patients who have to be worked into regular schedules.

Hidden Ingredient

Pensacola has been progressive in the mental health field and successful in meeting the needs of patients. One ingredient in this success appears to be the friendly, enthusiastic person-to-person cooperation usually on a first name basis and a hearty optimistic can-do attitude on the part of key citizens, hospital administrators and leading physicians. Mix in aggressive public spirited psychiatrists willing to work hard at whatever they feel will benefit their community and this completes the recipe for success.

These psychiatrists enter into community life actively and are striking antitheses of the ivory tower dwellers. They have served as chief of staff at the major hospitals, president of the county medical society, on advisory councils to the Juvenile Court, Fine Arts Council, and many more. They appear as guest speakers and actively seek financial support for worthy projects. Their warm and friendly manner is seen in all interpersonal contacts. Talk community mental health to one of them and he appears to know everyone in town. It is not name dropping or a brash lack of dignity but an obvious respect for the other man.

Pensacola has not reached all its goals. There are needs, but somehow this Gulf Coast city, steeped in history yet strikingly alert to the future, will find a way to meet them in the outstanding manner it has in the recent past. With good citizens working amicably together any city could.

▶ Dr. Phillips, 1515 West Moreno Street, Pensacola 32501.

Medical Care as a Right: A Refutation

Abstract: From man's primary right—the right to his own life—derive all others, including the rights to select and pursue his own values, and to dispose of these values, once gained, without coercion. The choice of the conditions under which a physician's services are rendered belongs to the physician as a consequence of his right to support his own life.

If medical care, which includes physician's services, is considered the right of the patient, that right should properly be protected by government law. Since the ultimate authority of all law is force of arms, the physician's professional judgment—that is, his mind—is controlled through threat of violence by the state. Force is the antithesis of mind, and man cannot survive qua man without the free use of his mind. Thus, since the concept of medical care as the right of the patient entails the use or threat of violence against physicians, that concept is antimind—therefore, antilife, and, therefore, immoral.

Robert M. Sade, M.D.

Reprinted from the New England Journal of Medicine, December 2, 1971.

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1. Gordon, E. E. and Haas, A., Indust. Med. & Surg. 28:217, May, 1959.

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Editorials

Your Elected

Why should any doctor want to become a member of the House of Delegates of the AMA? A recent publication states that the major motivation for many is a desire for service to the profession and to the public. Others seek such jobs to advance their particular political ideas, while with some, it is the wish to ride a personal hobby horse. There also are very human motives such as distinction and recognition back home.

It is a long, long climb up to the status of delegate, where once there, the job is both time-consuming and costly. Years go by before most work their way up to such eminence, for a man early in his practice is not able to afford both an important loss of practice income plus the appreciable sum in out-of-pocket expense. Before becoming full-fledged delegates, AMA members usually have served a minimum of five years in their county society, several years at the state level and three years as alternate delegate. The median age at which they attain full status is 52 but the average delegate is 59 years old. Only one delegate is under 40.

One chore that really bothers delegates is the sheer volume of the material the House must consider and vote on which grows in amount and complexity with each year. This information often is available too late for the delegate to understand or study carefully. Suggestions for longer and more frequent meetings instead of the present four or five day sessions have been made on the assumption that things are moving too fast for semiannual meetings.

Some critics think that the scientific programs should be left to specialty groups and allow the AMA to concentrate on socioeconomic issues or other things common to all practicing physicians. Young practitioners and medical students complain that the AMA is unimaginative, irresponsive, nonprogressive and without leadership, and as so few young men are elected to the House they are inadequately represented for older men cannot visualize problems that badger those new in practice. Nevertheless, in this state, younger men *are* being nominated as delegates to the AMA and are being elected. Furthermore, opening membership to medical students, interns and residents; as well as other means of providing platforms for younger voices and younger opinions, should be explored.

Our delegates to the AMA are there because of their general wisdom and judgment, their knowledge of the problems of organized medicine, an ability to appear before the public as spokesmen for medicine, the opinion other FMA members have of them, their geographic area and their years of service to FMA. Our delegates are truly outstanding and should be given a pat on the back for their many hours away from home and practice, for sitting through all-day meetings and for reading reports far into the night in order to talk, to debate and to vote in our best interests at the annual AMA meetings.

Many, many thanks to our delegates and alternates who are:

Francis T. Holland, M.D., (Chairman) Delegate, Tallahassee
Francis C. Coleman, M.D., Alternate, Tampa
Samuel M. Day, M.D., Delegate, Jacksonville
Jack Q. Cleveland, M.D., Alternate, Coral Gables
Richard G. Connar, M.D., Delegate, Tampa
Robert E. Zellner, M.D., Delegate, Orlando
James T. Cook, M.D., Alternate, Marianna
Burns A. Dobbins Jr., M.D., Delegate, Fort Lauderdale
Eugene G. Peek Jr., M.D., Alternate, Ocala
Rufus K. Broadaway, M.D., Delegate, Miami
Thomas B. Thames, M.D., Alternate, Orlando

C.M.C.

The New Relative Value Manual

Fred A. Butler, M.D.

The new 1971 Relative Value Manual has been completed after three years of work by the Relative Value Studies Committee. This revision has been a massive undertaking with adoption of the AMA Current Procedural Terminology (CPT) and five digit coding for all procedures, a survey of all private physicians in Florida, and evaluation and assignment of relative values to the 3,600 procedures and services included. An actuary statistician, William Howard, Ph.D., Inc., has been a consultant and assistant to the committee throughout, and has provided essential advice and handled most of the details of the revision.

This manual holds a wealth of useful information and will, it is anticipated, be a reliable guide to physicians and their assistants in describing and coding procedures and in determining charges. Because of changes in format, a large increase in total procedures and a number of innovations, it is strongly urged that all physicians and staffs as well as interested third-party groups study the manual carefully before use.

Coding has been changed to five digits to accommodate the present increase in number of procedures and increases anticipated for the future. A system of modifiers to indicate various changes in procedures has been included and should facilitate description of procedures and billing. A new and more logical grouping of musculoskeletal and pathology procedures has been introduced. Radiology has been considerably expanded, and all radiology terminology is from the partially completed Third Edition of CPT.

This is the only section of the Third Edition available at present and contains a much needed amplification of angiographic and other radiology procedures. A recent communication from the AMA office of Current Medical Terminology indicates that the Third Edition will include some rearrangements of the index and sections but that the terminology and coding will remain "reasonably stable."

A suggested Professional Component has been retained from the 1968 Florida Manual for Pathology and Radiology as it was considered a reliable and useful guide for hospital-based pathologists and radiologists who employ direct billing.

A manual of this size and complexity will inevitably contain errata. Corrections will be appreciated. The next major assignment of the Committee is to develop a modus operandi for active continuous manual revision to keep pace with changing patterns of practice and procedures.

Dr. Butler is Chairman, FMA Committee on Relative Value Studies.

Dr. Butler, 1262—3rd Street, Naples 33940.



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Consult direction circular before prescribing.

1. Edelman, B.A., Contractor, A.M., and Shangraw, R.F.: The stability of hypodermic tablets of nitroglycerin packaged in dispensing containers, J. Amer. Pharm. Ass. **NS11**:30 (January) 1971.

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Use in conjunction with phenformin is indicated when optimal control is not obtained with Orinase or phenformin alone.

Contraindications: Orinase alone is not effective in juvenile or growth-onset diabetes nor in unstable brittle diabetes where insulin therapy is required.

Orinase should not be used: when diabetes is complicated by acidosis, ketosis, or coma, or when a history of repeated bouts of acidosis or coma is obtained; in the presence of other acute complications such as fever, severe trauma, or infections; and in patients with severe renal insufficiency. Insulin is indicated in these circumstances.

Pregnancy Warning: The safety and usefulness of Orinase during pregnancy has not been established either from the standpoint of the mother or the fetus. Animal studies have demonstrated feticidal and teratogenic effects of doses of 1,000-2,500 mg./kg./day, but application to human subjects unknown. Therefore, Orinase is not recommended for the pregnant diabetic, and when administering Orinase to women of childbearing age, these facts should be borne in mind.

Precautions: Diagnostic and therapeutic measures necessary for optimal control with insulin are also necessary with Orinase. The patient on Orinase must be fully instructed: about the nature of his disease; how to prevent and detect complications; how to control his condition; not to neglect dietary restrictions, develop a careless attitude or disregard instructions relative to body weight, exercise, personal hygiene, and avoidance of infection; how to recognize and counteract impending hypoglycemia; how and when to test for glycosuria and ketonuria; how to use insulin; and to report to the physician immediately if he does not feel as well as usual.

Caution, very close observation, and careful adjustment of dose are necessary when: insulin is withdrawn during the trial period in order to avoid ketosis, acidosis, and coma; thiazide diuretics are administered which may result in aggravation of diabetic state and increased tolbutamide requirement, temporary loss of control, or even secondary failure; treating patients with impaired hepatic and/or renal function and debilitated, malnourished, or semistarved patients in order to avoid severe hypoglycemia which may require corrective therapy over several days; and treating patients with severe trauma, infection, or surgical procedures where temporary return to insulin or addition of insulin may be necessary. Response to tolbutamide is diminished in patients receiving therapy with beta blocking agents.

As some diabetics are not suitable candidates, it is essential that the physician familiarize himself with the indications, limits of application, and selection of patients for therapy.

Patients must be under continuous medical supervision, and during the initial test period should communicate with the physi-

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cian daily, and during the first month report at least once weekly for physical examination and definitive evaluation. After a month, examinations are recommended monthly or as indicated. Appearance of ketonuria, increase in glycosuria, unsatisfactory lowering or persistent elevation of blood sugar, or failure to obtain and hold clinical improvement indicate nonresponsiveness to Orinase (tolbutamide). Orinase does not obviate need for maintaining standard diet regulation. Uncooperative patients should be considered unsuitable for therapy. Prescriptions should be refilled only on specific instruction of physician. In treating mild asymptomatic diabetic patients with abnormal glucose tolerance, glucose tolerance tests should be obtained at three- to six-month intervals. Orinase is not an oral insulin or a substitute for insulin and must not be used as sole therapy in juvenile diabetes or in diabetes complicated by acidosis or coma where insulin is indispensable.

If phenformin is prescribed in combination with Orinase, appropriate package literature should be consulted.

Adverse Reactions: Severe hypoglycemia, though uncommon, may occur and may mimic acute neurologic disorders such as cerebral thrombosis. Certain factors such as hepatic and renal disease, malnutrition, advanced age, alcohol ingestion, and adrenal and pituitary insufficiency may predispose to hypoglycemia and certain drugs such as insulin, phenformin, sulfonamides, oxyphenbutazone, salicylates, probenecid, monamine oxidase inhibitors, phenylbutazone, bishydroxycoumarin, and phenyramidol may prolong or enhance the action of Orinase and increase risk of hypoglycemia. Orinase long-term therapy has been reported to cause reduction in RAI uptake without producing clinical hypothyroidism or thyroid enlargement and at high doses is mildly goitrogenic in animals. Photosensitivity reactions, disulfiram-like reactions after alcohol ingestion, and false-positive tests for urine albumin have been reported.

Although usually not serious, gastrointestinal disturbances (nausea, epigastric fullness, and heartburn) and headache appear to be dose related and frequently disappear with reduction of dose or administration with meals. Allergic skin reactions (pruritus, erythema, urticaria, and morbilliform or maculopapular eruptions) are transient, usually not serious, and frequently disappear with continued administration. Orinase should be discontinued if skin reactions persist. Recent reports indicate that long-term use of Orinase has no appreciable effect on body weight.

Orinase appears to be remarkably free from gross clinical toxicity: crystalluria or other renal abnormalities have not been observed; incidence of liver dysfunction is remarkably low and jaundice has been rare and cleared readily on discontinuation of drug (carcinoma of the pancreas or other biliary obstruction should be ruled out in persistent jaundice); leukopenia; agranulocytosis; thrombocytopenia; hemolytic anemia; aplastic anemia; pancytopenia; and hepatic porphyria and porphyria cutanea tarda have been reported.

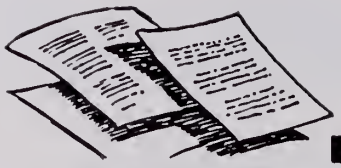
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Letters

Dear Editor:

I would like to express to you that I am in agreement with the AMA's House of Delegates resolution adopted at both the 1970 and 1971 conventions opposing the repeal of the Federal Anti-Substitution Act.

At the Annual Convention of the National Association of Retail Druggists held in New Orleans, October 10-14, 1971, the following resolution was adopted:

> **Whereas,** There still exists controversy regarding repeal of anti-substitution laws, and
>
> **Whereas,** The membership decrees that the repeal of anti-substitution laws in the various states is not in the best interest of the public health,
>
> **Resolved,** That the NARD continue vigorously to oppose the repeal of anti-substitution laws,
>
> **And further resolved,** That the NARD initiate and direct a study of the complicated facets of the brand-interchange concept.

The resolution reflects our awareness of the cross currents which affect health care programs in the United States covering every aspect of the various fields concerned; therefore, I am sure the study of the problem will continue.

It should be understood that the position held by the vast majority of independent pharmacists in the United States is in direct opposition to any repeal of such laws which will entitle the pharmacist to move into what we consider an area of strict medical practice. We welcome the opportunity to consult with physicians on drug products in general, and this, of course, has been standard practice throughout the years. The term "drug consultant" to the practicing physician reflects this position, however, there is a distinction between this term and the move to expand its functions to include individual encroachment on the physician's right and responsibility to select a drug of choice for his individual patients.

I agree that it is the right of the physician to select the drug of choice and the manufacturer he desires, for I am sure he knows what is most therapeutically effective.

JOHN W. WHITE, REGISTERED PHARMACIST
TALLAHASSEE, FLORIDA

Dear Mr. White:

Thanks so much for your letter expressing your views on the anti-substitution laws. Since this information will be helpful to the practicing physician, we plan to publish it in the February issue of the Journal.

I am sure that there are many of us on the prescribing side of the profession who are grateful to have people like you on the dispensing side.

CLYDE M. COLLINS, M.D.
EDITOR

Dear Dr. Collins:

Please accept my congratulations on the excellent article, "Podiatrists, the Other Doctors," which appeared in the November 1971 issue of the Journal of the Florida Medical Association.

I know I speak for the entire Association when I say that such accurate and informative articles as this contribute significantly to better understanding between all members of the health professions.

ERNEST M. WEINER, D.P.M., FACFS, *President*
AMERICAN PODIATRY ASSOCIATION
NEW YORK, N. Y.

Dear Editor:

I refer to the special article Coding: Not Digits for Deception But Numbers for Know How* dealing with the significance of codes within our scope of reporting. The effort spent by some devoted worker for organized medicine, in its preparation is obvious, but, in its present state, is it not confusing?

In content, the author refers and emphasizes Current Medical Terminology, the current guideline published by AMA. In the table examples, together with their explanations, I can only comprehend them as applied to Workmen's Compensation cases. These codes are prescribed by the State Commission and we are already compelled to use them in our reporting. They dictate a prescribed fee. I am unable to comprehend within this content, how these codes can be applied in noncompensation cases, or how the author ties in these codes with the current guide book published by AMA on "Current Medical Terminology" which I have before me.

This new C.M.T. guide by AMA, has gratifyingly revised and simplified the code reporting for our hospital cases over the old system. Hospital staffs should move to adopt it universally; however, the codes in no way coincide with those used in the article under discussion.

The author has sounded a significant keynote, namely, the need for our thinking and action relative to attempting some uniformity of codes or abbreviations that could encompass hospital cases, relative values when necessary, noncompensation insurance cases, and probably other bureaucratic edicts that will be imposed soon. At present the various clerical aspects already saddled upon us is little short of a monsoon.

KENNETH PHILLIPS, M.D.
CORAL GABLES

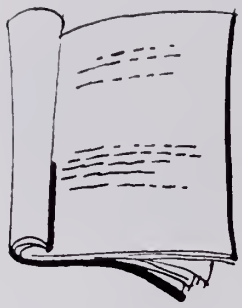
Editor's Note: The above mentioned article,* pages 44-46 of the December JFMA was based on the *AMA Current Procedural Terminology* and not Current Medical Terminology. The C.P.T. has been followed by the FMA Committee on Relative Value Studies (see page 46) and is being revised in a 3rd edition to appear this summer. The editorial "The Numbers Game—Our Style" did contain two errors. At the present time neither Florida Blue Shield nor Medicare accepts the AMA's Current Procedural Terminology. Only in California does HEW accept such a system. For these mistakes we apologize.



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On Being a Director

I feel particularly honored to have been on the Board of Directors of the Florida Academy of Family Practice for two years. That a relatively new member from the most isolated area of the state was given the privilege to represent the general membership was stimulating to me.

After serving as a director, I am convinced that every member of our state organization should be on the board at one time or another. This service removes many of the mysteries from the actions of our leaders. It shows that you need a compact active body to keep our organization viable, progressive and representative. It stresses that the directors actually are expressing their assessment of the feelings of the general membership. Very rarely was it even suggested to me that any one of our board members was using his office to further his own ambitions.

In a like vein, were it possible to rotate more members through the offices of the American Medical Association, I am certain that there would be much less criticism of the A.M.A. It is impossible to make a decision that will make everyone happy. The director of any organization has a special vantage point not usually available to the general membership. If the director is sincere, honest, and well-informed, his vote will be in the best interest of his group. It will not always be the best one as proved by the passage of time or turn of events, but it will express his true concern at the time. The directors of any organization cannot prevent the general erosion of morals, the changing of standards, the lessening of the loyalty of an employee, the fading appeal of patriotism, the blindness some have for our wonderful country when compared with all other existing countries, and the down-grading of rugged individualism.

Your directors have to take up endless problems as they arise, consider them from all angles, and then render the decision they feel is in your best interest, both for the present and the future. They cannot be perfect; however, those privileged to have been a director will be more tolerant of their leaders. Ex-directors are more likely to express their opinions before a decision is made and not use the retrospectoscope. They are more likely to appreciate the sacrifice that the leaders of the F.A.F.P. make in the sense of time, money, travel, and personal hardship.

I shall always be sincerely grateful that I had the honor of serving as your director. It made me a better member of the F.A.F.P. and more convinced that our organization is vital for the family physician as well as for medicine in general.

H. K. Moore, M.D.
Key West

Reprinted from Florida Family Physician, Fall, 1971, Vol. 21, No. 4.

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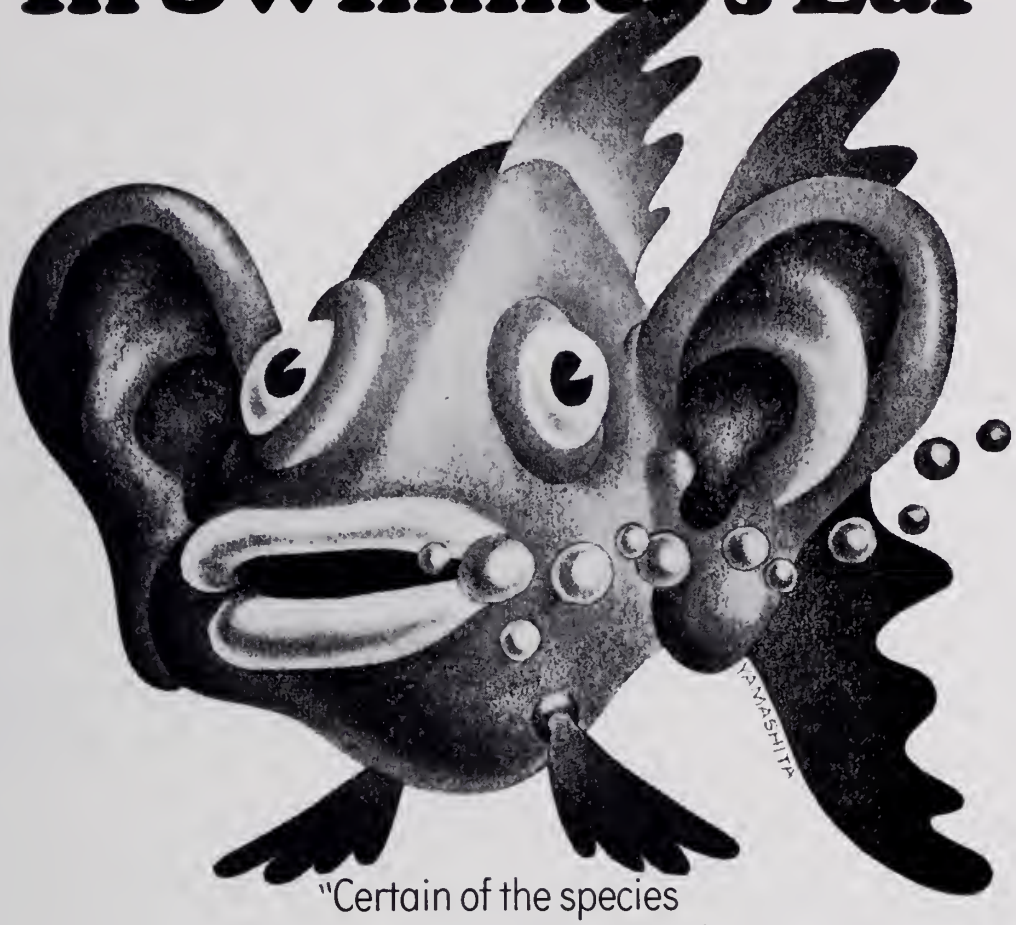
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Medical News

Examination Programs

Palm Beach County is one of 64 areas in the country included in a screening program to be conducted by the Health and Nutrition Survey of the U. S. Public Health Service.

About 510 county residents in the 1 to 74 age group will be invited to have health and nutrition examinations during a study beginning Jan. 19, 1972. The survey will attempt to collect statistical information on selected chronic disease conditions and on the nutritional status of the population.

Persons will be selected for the survey by scientific sampling techniques. Examinations will be conducted in a mobile center by a general examining physician, dermatologist, ophthalmologist, dentist, nurse, lab technician, two health technicians, secretary, three nutritionists, and a supporting staff of administrative personnel and interviewers.

Central Florida Medical Meeting

The Orange County Medical Society's 17th Annual Central Florida Medical Meeting will be held at Walt Disney World near Orlando, March 15-18, 1972.

Scientific discussions will relate to medical and surgical aspects of coronary artery disease, medical and surgical aspects of thyroid and parathyroid abnormalities, and antibiotics and infectious diseases.

The American Academy of Family Physicians has been asked to approve the program for 12 hours of credit. Registration fees are $50 for members of Orange County Medical Society and $100 for all other physicians except interns and residents, who are admitted free.

Additional information may be obtained by writing to Mr. Edward J. Edwards, Orange County Medical Society, 800 North Mills Avenue, Orlando, Fla. 32803.

In-Hospital Cancer Traineeships

The University of Miami School of Medicine has announced the availability of a number of in-hospital traineeships for practicing physicians interested in the problems of cancer.

Programs are variable and can be adjusted to each physician's individual needs and desires, according to an announcement from the School. Participating clinical departments or divisions are medicine, obstetrics and gynecology, pediatrics, surgery, otolaryngology, dermatology, radiology, nuclear medicine and pathology.

The program is sponsored by the Clinical Cancer Training Program of the School of Medicine and is supported by the National Cancer Institute.

Details may be obtained by contacting: Dr. Howard E. Lessner, Chief, Medical Oncology Division, University of Miami School of Medicine, P.O. Box 875, Biscayne Annex, Miami, Fla. 33152.

Emergency Physicians Elect Dr. Haeck

William T. Haeck, M.D., of Jacksonville, has been re-elected to the Board of Directors of the American College of Emergency Physicians. Dr. Haeck is President of the Florida Chapter of ACEP.

Certified in Pediatric Cardiology

Two Florida physicians recently were certified in pediatric cardiology by the American Board of Pediatrics. They are Lodewyk H. S. Van Mierop, M.D., and Benjamin Eduardo Victorica, M.D., both of Gainesville.

Clinical Scientist of the Year

Jeno E. Szakacs, M.D., of Tampa, has been cited by the Association of Clinical Scientists as "Clinical Scientist of the Year" for 1971. Dr. Szakacs was recognized for his contributions to clinical pathology and his work on viral oncogenesis of human sarcomas.

Dr. Stewart Is Honored

John S. Stewart, M.D., of Naples, President of the Collier County Medical Society, has been presented the Distinguished Service Award of the Florida Radiological Society.

Dr. Stewart was honored for his service as President of the Society, counselor to the American College of Radiology, and as a member of the Board of Chancellors of the national group.

The final order transferring phenmetrazine(Preludin) and its salts and methylphenidate (Ritalin) from Schedule III to Schedule II of the CSA for 1970 was published on October 28, 1971. Schedule II order form, prescription and record keeping requirements became effective January 1, 1972.



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Deaths

Buchanan, Arthur P., Leesburg; born 1916; McGill University, 1942; member AMA; died September 11, 1971.

Campbell, Francis J., Miami; born 1904; Boston College P & S, 1938; died September 8, 1971.

Cope, Paul T., St. Petersburg; born 1918; St. Louis University, 1943; member AMA; died October 23, 1971.

Coxe, Lemuel F. Jr., Panama City; born 1906; Tennessee Medical School, 1930; member AMA; died August 21, 1971.

Gilbert, Michel G., Miami; born 1926; New York University Bellevue, 1952; died November 29, 1971.

Klein, Warren E., Pompano Beach; born 1902; Tulane University, 1928; died August 26, 1971.

Raap, Gerard, Miami Shores; born 1895; University of Cincinnati, 1922; member AMA; died October 31, 1970.

Weiner, James M., Miami; born 1943; Boston University, 1968; member AMA; died May 23, 1971.



Death Claims Dr. Long

James A. Long Jr., M.D., one of the Florida Medical Association's first black members, died at his home in Palatka on December 12, 1971. He was 72.

At the time of his death, Dr. Long was preparing to retire from the American Medical Association's Committee on Medicine and Religion on which he had served for several years.

In recognition of his service on the AMA committee, a plaque had been prepared, and plans were being made to present it to Dr. Long during the Presidents and Secretaries Conference in Orlando in January.

A native of Daytona Beach, Dr. Long received his M.D. degree from Howard University in Washington, D. C., in 1925. He once served as Secretary-Treasurer of the Putnam County Medical Society. The Florida Medical Association presented him the 1966 A. H. Robins Community Service Award, given to the physician "who has rendered distinguished service in civic and community activities." He was a member of several other medical organizations, including FMA, AMA and the National Medical Association.

Survivors include the widow, one daughter and a sister.



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Walter Birnbaum, M.D., San Francisco, Calif.
Colon & Rectal Surgery
Richard Winkelmann, M.D., Rochester, Minn.
Dermatology
H. Worth Boyce Jr., M.D., Washington, D.C.
Gastroenterology
J. Jerome Wildgen, M.D., Kalispell, Montana
General Practice
William A. Little, M.D., Miami, Fla.
Gynecology
Sol Sherry, M.D., Philadelphia, Pa.
Internal Medicine
Noble Fowler, M.D., Cincinnati, Ohio
Internal Medicine
Frank H. Mayfield, M.D., Cincinnati, Ohio
Neurosurgery
C. D. Christian, M.D., Ph.D., Tucson, Ariz.
Obstetrics
Roderick Macdonald Jr., M.D., Louisville, Ky.
Ophthalmology
J. T. Hartman, M.D., Lubbock, Tex.
Orthopedic Surgery
Robert B. Lewy Jr., M.D., Chicago, Ill.
Otolaryngology
John Bernard Henry, M.D., Syracuse, N.Y.
Pathology
Arnold P. Gold, M.D., New York, N.Y.
Pediatrics
George N. Stein, M.D., Philadelphia, Pa.
Radiology
W. Gerald Austen, M.D., Boston, Mass.
Surgery
John E. Hoopes, M.D., Baltimore, Md.
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Harry M. Spence, M.D., Dallas, Tex.
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ORGANIZATION

Committee on Continuing Medical Education

William H. Hubbard, M.D., of Daytona Beach, presided at a meeting of the FMA Committee on Continuing Medical Education at Miami Springs last November.

A recommendation was adopted that the FMA undertake the evaluation and approval of postgraduate education programs of medical schools and approved hospitals. The Committee volunteered its services in the development of guidelines for this purpose.

There was further discussion of the Committee's proposal that FMA members be required to take a minimal number of hours of postgraduate education per year. A draft of the program will be prepared for consideration at the next meeting.

Ad Hoc Committee on Drug Abuse

FMA's Ad Hoc Committee on Drug Abuse acted on a variety of proposals on drug-related matters at its meeting in Miami Springs last November.

The Committee, chaired by Robert P. Johnson, M.D., of Tallahassee, went on record as discouraging further prescription of amphetamines except for narcolepsy and the hyperkinetic child.

Identified as "a matter of the highest priority in Florida" was provision of central urine screening services. The Committee called upon the Florida Division of Health to provide such screening at no charge for all licensed drug programs and centers.

Another Committee recommendation was that physicians place signs in their reception rooms encouraging patients to discuss drug problems.

It was reported that the Physicians Desk Reference on Drug Abuse was almost ready for printing and distribution.

Ad Hoc Committee on Drug Abuse

The Ad Hoc Committee on Drug Abuse heard subcommittee reports and acted on a variety of matters at its December 15 meeting in Orlando.

The Committee found itself in favor of the proposed education of drug abuse counselors and teachers by the Department of Education. However, it said that treatment and rehabilitative aspects of the drug problem should be under the jurisdiction of a health-related agency.

In other action, the Committee commended the Florida Association of Broadcasters for its efforts in the drug abuse problem; and decided to reconsider at a later date legislation allowing physicians to treat minors for drug problems without parental consent.

Health in Retirement Communities

The Florida Committee on Rural Health wants stronger attention given to the health needs of retirement communities.

At a recent meeting, the Committee went on record as favoring legislation to require retirement community developers to make provisions for such needs for community residents.

Among other actions at the Committee's meeting at Mayo on Dec. 9, 1971, was the re-election of Arthur M. Riley, D.D.S., as Chairman of the Committee. Dr. Riley serves on the Committee as a representative of the Florida Dental Association.

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CLINICAL DIRECTOR:
Hordin M. Ritchey, M.D., F.A.P.A.

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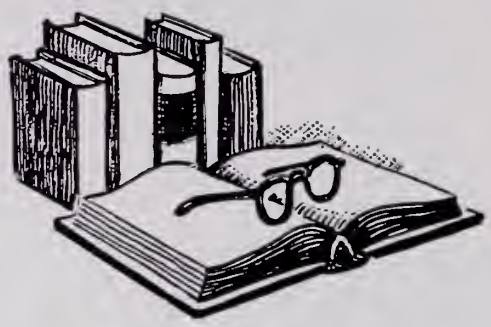
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Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

Symposium on the Functional Physiopathology of the Fetus and Neonate, Clinical Correlations. Edited by Harold Abramson, M.D. Pp. 182. 61 illustrations. Price $15.00. St. Louis, The C. V. Mosby Company, 1971.

Handbook of Clinical Dermatoglyphs by Musallam S. Elbualy and Joan D. Schindeler. Pp. 64. Price $6.95. Coral Gables, University of Miami Press, 1971.

Synopsis of Pediatrics by James G. Hughes, M.D. Pp. 1141. Illustrated. Price $14.50. St. Louis, The C. V. Mosby Company, 1971.

Stereocolposcopic Atlas of the Uterine Cervix by Joseph W. Scott, M.D. Pp. 117. Illustrated. Kendall, Florida, Zephyr Publishers, 1971.

CRC Manual of Nuclear Medicine Procedures by William H. Beierwaltes, M.D., John W. Keyes Jr., M.D. and James E. Carey, M.S. Pp. 137. Price $19.90. Cleveland, Ohio, CRC Press, 1971.

Biochemical Profiling in Diagnostic Medicine by Joseph A. Preston, M.D. and David B. Troxel, M.D. Pp. 51. Price $2.50 for set of five. Tarrytown, New York, Technicon Instruments Corporation, 1971.

Radiation Protection Standards by Dr. Lauriston S. Taylor. Pp. 110. Price $11.50. Cleveland, Ohio, CRC Press, 1971.

Proceedings of the International Conference on Nosocomial Infections. Pp. 334. Illustrated. Price $1.50. Chicago, American Hospital Association, 1971.

Lumbar Disc Disease, A Twenty-Year Clinical Follow-up Study. Edited by Blaine S. Nashold Jr., M.D. and Zdenek Hrubec, Sc.D. Pp. 139. Price $16.50. St. Louis, The C. V. Mosby Company, 1971.

Review of Physiological Chemistry by Harold A. Harper, Ph.D. Pp. 529. Illustrated. Price $8.00. Los Altos, California, Lange Medical Publications, 1971.

Management of High-Risk Pregnancy and Intensive Care of the Neonate by S. Gorham Babson, M.D., and Ralph C. Benson, M.D. Pp. 313. 62 illustrations. Price $16.50. St. Louis, The C. V. Mosby Company, 1971.

Handbook of Poisoning by Robert H. Dreisbach, M.D., Ph.D. Pp. 515. Illustrated. Price $6.00. Los Altos, California, Lange Medical Publications, 1971.

Book Review

Review of Medical Physiology by William F.Ganong, M.D. Pp. 573. Illustrated. Price $8.50. Los Altos, California, Lange Medical Publications, 1971.

William F. Ganong, professor of physiology at the University of California Medical School, has written his Fifth Edition of the *Review of Medical Physiology* which also is being published in foreign languages.

The purpose of the book is to provide a pertinent summary of mammalian and human physiology for medical students and others. This material may be supplemented by reading other sources, some of which are given in the text.

Subjects covered are the Brain and Nervous System, Muscles, Endocrines, Gastrointestinal system, Bones, Cardiovascular, Renal and Respiratory. The cutaneous organ for some reason is not mentioned.

The book is a paperback, containing 573 pages and sells for $8.50, which is quite reasonable in a day when medical books are very high in cost.

Any attempt to cover medical physiology in a day and age when advances are so rapid is quite commendable and borders almost on the heroic. Ganong's review is very good and one can quite easily find a quick summary of a particular subject in which he is interested. It is a good reference book for the busy practitioner.

PERRY A. SPERBER, M.D.
DAYTONA BEACH

MEETINGS

Approved by FMA Committee on Continuing Education

MARCH

1- 4 Medical Malpractice, A Legal Course for Physicians, Americana Hotel, Miami Beach. For information: Prof. Walter H. Beckham Jr., Box 8087, Coral Gables, Florida 33124.

4 Sixteenth Watson Clinic Annual Seminar, Watson Clinic, Lakeland. For information: Brunildo A. Herrero, M.D., Watson Clinic, Lakeland, Florida 33802.

15-18 Fourth Teaching Conference in Clinical Cardiology, Sheraton-Four Ambassadors Hotel, Miami. For information: Michael S. Gordon, M.D., Box 875, Biscayne Annex, Miami 33152.

15-19 Fourth Annual Nuclear Medicine Seminar, Playboy Plaza Hotel, Miami Beach. For information: Susan R. Cohen, B.A., Div. of Nuclear Medicine, Box 875, Biscayne Annex, Miami 33152.

21-25 Selected Topics in Gastrointestinal Roentgenology, Fontainebleau Hotel, Miami Beach. For information: Manuel Viamonte Jr., M.D., Box 875, Biscayne Annex, Miami 33152.

24-25 Postgraduate Surgical Symposium, Cedars of Lebanon Hospital, Miami. For information: Eugene L. Komrad, M.D., Cedars of Lebanon Hospital, 1321 N.W. 14th St., Miami 33125.

Florida State Board of Medical Examiners:
July 23-25, 1972, Miami Beach

For information: Mrs. Marjoriann Keebler, Administrative Assistant, Florida State Board of Medical Examiners, 2717 E. Oakland Pk. Blvd., Fort Lauderdale, Fla. 33306.

National and Regional Meetings Held in Florida

APRIL

3- 8 American College of Radiology, Fontainebleau Hotel, Miami Beach. Ex. Dir.: William C. Stronach, J. D., 20 N. Wacker Dr., Chicago 60606.

18-20 American Academy of Facial Plastic and Reconstructive Surgery. Sec.: Carl N. Patterson, M.D., 1110 W. Main St., Durham, North Carolina 27701.

23-24 American Otological Society, Breakers Hotel, Palm Beach. Sec.: Wesley H. Bradley, M.D., 1111 E. Genessee St., Syracuse, N.Y. 13210.

24-25 American Broncho-Esophagological Association, Hollywood Beach Hotel, Hollywood. Walter H. Maloney, M.D., 2065 Adelbert Rd., Cleveland 44106.

24-28 Association for Research in Vision and Ophthalmology, Sheraton Sandcastle, Sarasota. Sec.: Herbert E. Kaufman, M.D., Dept. of Ophthalmology, University of Florida College of Medicine, Gainesville 32601.

25-26 American Society for Head and Neck Surgery, Breakers Hotel, Palm Beach, Sec.: William M. Trible, M.D., 1234-19th St., N.W., Washington, D.C. 20001.

25-27 American Laryngological, Rhinological and Otological Society, Breakers Hotel, Palm Beach. Ex. Secy.: Louis E. Silcox, M.D., 108-111 Lankenau Medical Bldg., Philadelphia, Pa. 19151.

28-29 American Laryngological Association, Breakers Hotel, Palm Beach. Sec.: Frank D. Lathrop, M.D., R.D. #1, Pittsford, Vt. 05763.

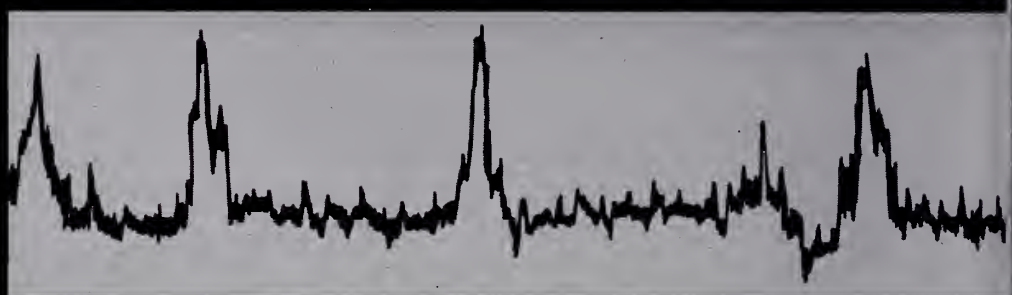
MAY

8-11 Aerospace Medical Association, Americana Hotel, Miami Beach, Ex. V.P., Merrill H. Goodwin, M.D., Washington National Airport, Washington, D. C. 20001.

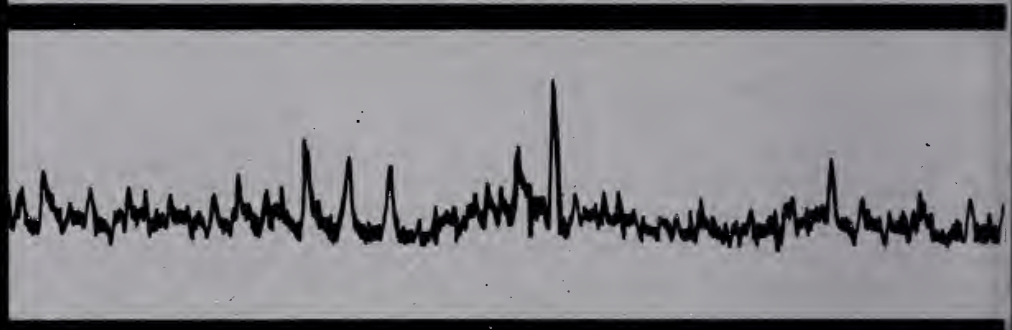
14-19 American Radium Society, Boca Raton, Florida. Sec.: Jerome M. Vaeth, M.D., 1600 Divisadero St., San Francisco 94115.

An intestinal autobiography of rage, contentment and horror*

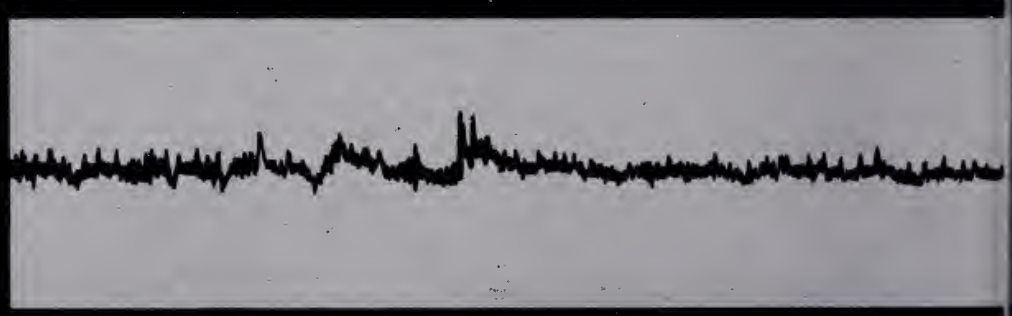
"Feeling unfairly taxed by the government (Internal Revenue Service) and not given enough attention by A.U.O. [an experimenter to whom the subject became very attached], he became overtly critical and accusatory. He shouted, raged, and threatened to quit."*



"The motility that day was quiet. This type of recording is seen regularly when he is relaxed and contented and the laboratory seems peaceful."*



He was overwhelmed by "paralyzing horror" when told he would need a partial laryngectomy for removal of an early carcinoma; "...the activity of the ileum virtually ceased for over a five-minute period...."*



Background

*Data presented here derive from a 13-year ongoing study by Henry Harrison Sadler, M.D., and Aline Underhill Orten, Ph.D., at Wayne State University. Their findings, which demonstrate a correlation between the emotional state of a human subject and the motility of an isolated segment of his ileum, were published in the April, 1968, *American Journal of Psychiatry*, volume 124, page 1375.

The subject is a 56-year-old man with a 40-cm Thiry loop of ileum created as a result of emergency surgery. A person of modest attainment and simple tastes, the subject depends on the investigators as he might his own family. His full-time job is as a "human laboratory," and throughout the 13-year period of the study, he has taken great personal pride in his own participation.

A story charged with emotion

The graphs on the facing page are intestinal motility readings on a human subject experiencing the emotions of rage, contentment and horror (see "Background" below left). This "intestinal autobiography" dramatizes the point that certain emotions correlate with specific patterns of G.I. motility.

The visceral clutch and functional G.I. disorders

The gut response to stress has been amply demonstrated in many functional G.I. disorders. Nervous diarrhea and irritable colon syndrome, for example, are disorders associated with abnormal G.I. motility. And these disorders are commonest among patients sensitive to life-stress situations productive of conflict and excessive anxiety.

Librax® calms anxiety, calms the gut

In these areas of G.I. pathology, Librax has become a mainstay of adjunctive therapy. Reason? Effective two-way calming action. Librax, by relieving excessive anxiety, not only helps calm emotional overreaction to stress, it controls intestinal hypermotility, too. Depend on Librax—the only drug that combines the well-known antianxiety action of Librium® (chlordiazepoxide HCl) and the potent, dependable antisecretory/antispasmodic action of Quarzan® (clidinium Br).

1 or 2 capsules, 3 or 4 times daily in the treatment of nervous diarrhea and irritable colon syndrome

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances, syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

In functional G.I. disorders, adjunctive Librax®

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Woman's Auxiliary

Comments From the Distaff Side

Bennie (Mrs. Arnold J.) Spanjers

Dr. Hurt has presented our husbands with the medical aspects of a physical fitness program on the President's Page this month and asked that we add our female thoughts.

Statistically, women as a group have less heart attacks than men: however, menopause seems to be the dividing line when incidences arise, so it would seem logical that increased physical activity in women has the same beneficial effects as in men, but at a later time in life.

Society has made us conscious of the need to exercise, and whether or not we like it, fashion demands that every woman look younger, no matter what her age. Men's clothing can hide their excess flab, but ours does everything to show it.

Aside from being fashion conscious, life and health are dependent on how fit our hearts and lungs may be. We must embark on a plan of exercise that not only tones up the body, but tones up the heart and respiratory system as well.

One punster said that most people over 30 exercise by running down their friends, jumping to conclusions, side-stepping responsibility, and pushing their luck. How much better it would be if we ran or jogged with friends, did a little old fashioned rope jumping, performed side-kicks for fatty thighs, and pushed away from the table.

After the 'go-ahead' from your own physician, find a gym or health spa that can give you a proper set of exercises to tone up pudgy areas. Not all exercises are necessarily for you. Many increase size where increases are undesirable so the proper selection is most important. Make certain that running or jogging is part of the program, for this builds endurance, confidence and your days will really be alive. This vigorous type of exercise can be done by yourself and it's a great time to be alone with your thoughts. Or if you like companionship, run with a friend. It's wonderful to be outdoors with someone whose friendship you value.

Have a working plan with your exercise program for you're going to be doing it the rest of your life. And working by plan will insure regularity, moderation, and variety. Exercise should be interesting so include as much variety as possible. Work hard, but don't strain. And remember, the harder you work the greater the need for rest. Gradually increase stress as it will prevent over-exertion and the danger of unaccustomed burden on the heart, lungs, and other parts of the body. Regularity is the key-word, for there are no lasting benefits when you haphazardly work out.

The doctor's wife of the 70's must run and exercise for good health, for the extra energy it will give, and for the happier outlook that comes when you know you look and feel better. Do this for yourself and your family, but mostly for that man—your doctor husband who needs you —physically fit.

Mrs. Spanjers, 1700—15th Street, N.W., Winter Haven 33880.

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Catherine T. Ray, M.D.

Classified Ads

physicians wanted

General Practitioners

GENERAL PRACTITIONERS OR INTERNISTS: Needed in Gulf Coast, central Florida community hospital of 75 beds, going to 115. Contact Administrator, Tarpon Springs General Hospital, 1395 S. Pinellas Avenue, Tarpon Springs, Florida 33589. Phone (813) 937-5161.

WANTED: ASSOCIATE FOR FAMILY PRACTITIONER in Fort Lauderdale area. Age 34. Florida license required. No obstetrics or major surgery. Financial arrangements open. Send resume to C-530, P.O. Box 2411, Jacksonville, Florida 32203.

GENERAL PRACTITIONER WANTED to associate with solo general practitioner in South Miami, Florida. Write C-518, P.O. Box 2411, Jacksonville, Florida 32203.

FAMILY PHYSICIAN AND INTERNIST WANTED: To join specialty group in rapidly growing area. Salary and partnership negotiable. Excellent 450-bed new hospital. Contact James Morgan, M.D., 400 Avenue "K," S.E., Winter Haven, Florida 33880.

WANTED: Family physician, internist to join established group in one of fastest growing areas of nation on Florida West coast. Group now consists of diplomate ABFP, board surgeon, board eligible surgeon and 2 family physicians who are AOA. Above average guarantee against gross. 46-week year. Call or write or visit James M. Marlowe, M.D., P.O. Box 1058, New Port Richey, Florida 33552. Phone (813) 849-2238.

Specialists

INTERNIST, UROLOGIST, GP's.: Outstanding opportunities in progressive nonurban community serving 20,000. Write John H. Parker, M.D., Chief of Staff, Doctors Memorial Hospital, Perry, Florida 32347.

INTERNIST WANTED: For association, greater Miami area, Please send curriculum vitae to C-524, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST: Board eligible or certified for association in new office. Outstanding opportunity for eager individual. Terms open. Excellent hospital facilities. Irwin Leider, M.D., 240 N. Frederick Avenue, Suite B, Daytona Beach, Florida 32014.

CHIEF RADIOLOGIST WANTED: For 520 bed accredited community hospital in Hollywood, Florida. Write Dr. Marvin S. Allen, Chief of Staff, Memorial Hospital, 3501 Johnson Street.

INTERNIST WANTED: Board eligible or certified, preferably with subspecialty, interest in hematology and/or gastroenterology to join flourishing practice in Fort Lauderdale area. Excellent salary and fringe benefits first year, leading to association. Must have Florida license. Please phone (305) 565-6434.

NEEDED IMMEDIATELY: Four internists, urologists, orthopedists and general surgeon for practice in area of rapid growth. Modern local hospitals. Contact Warren A. Clark, M.D., P.O. Box 1376, New Port Richey, Florida 33552. Phone (813) 849-1386.

PSYCHIATRIST: Take over thriving psychiatric practice for cost of furnishings and equipment. Excellent location leading South Florida East Coast city. Illness forces sale. Write C-526, P.O. Box 2411, Jacksonville, Florida 32203.

PEDIATRICIAN URGENTLY NEEDED: Due to illness of one of two practicing pediatricians. Middle Florida community (25,000) with outstanding university, excellent educational facilities, small town environment. Twenty miles from Daytona, 40 miles from Orlando and Disney World. Two recognized medical staffed hospitals (total 150 bed). All specialties represented except neurosurgery and thoracic surgery. Retiring pediatrician will be able to introduce and turn over records. Furnished office available immediately if desired. Address inquiries to: P.O. Box 2075, Deland, Florida 32720. Phone (904) 734-9312.

A BOARD CERTIFIED OR ELIGIBLE OB-GYN with military obligation completed, is wanted to join a solo, incorporated board certified Ob-Gyn in south Florida. Florida license required. Salary first year leading to full partnership. Contact C-529, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST WANTED: Board eligible or certified, married, military service completed. Join growing busy internal medical practice. Suburban Miami area. Write Box C-527, P.O. Box 2411, Jacksonville, Florida 32203.

WANTED: Urologist, Ob-Gyn, Internist, orthopaedist to join expanding group of young, well qualified family physicians and surgeons now consisting of diplomate ABFP, board certified surgeon, board eligible surgeon and 2 family physicians who are AOA. Service area of about 80,000 served by 10 M.D.s; one of fastest growing in entire nation. Two hospitals with open staffs. Additional office space soon available. Above average guarantee against gross. 46-week year. Call or write or visit James M. Marlowe, M.D., P.O. Box 1058, New Port Richey, Florida 33552. Phone (813) 849-2238.

CHIEF PATHOLOGIST WANTED: For 520 bed accredited community hospital in Hollywood, Florida. Write Dr. Marvin S. Allen, Chief of Staff, Memorial Hospital, 3501 Johnson Street.

Miscellaneous

PHYSICIANS WANTED IN FLORIDA, DIVISION OF MENTAL HEALTH: Positions are available for qualified physicians (Florida license not required). General practitioners, internists, surgeons, psychiatrists—in the hospital facilities of the Division of Mental Health. Interest, accompanied by a curriculum vitae, should be directed to E. Arthur Larson, M.D., Deputy Director for Hospitals and Institutes, Division of Mental Health, 200 East Gaines Street, Room 425, Tallahassee, Florida 32304.

WANTED IMMEDIATELY: Private emergency room physician. Corporate group needs fifth physician in teaching hospital, Orlando, Florida. Prefer GP. Florida license required. Contact Bruce S. Webster, M.D. (305) 647-5728 or Robert Gay, M.D. (305) 422-0159.

PHYSICIANS NEEDED: Tallahassee, Leon County, Northwest. General practitioners, internists and pediatricians in particular. Inquiries regarding practice in this community can be forwarded to J. Orson Smith Jr., M.D., Chairman, Physician Procurement Committee, 1433 Miccosukee Rd., Tallahassee, Fla. 32303. Phone (904) 877-1145.

DUNEDIN, Pinellas County, middle west coast, Clearwater area. Thirty-six physician multispecialty group seeking internist-gastroenterologist, neurologist, pathologist, obstetrician-gynecologist, GP, and emergency room physician. Affiliated general hospital just expanded to 308 beds. Clinic expansion to be completed January 1972. Long range plans for 650 beds and 75-physician clinic. No investment required. Contact Donald M. Schroder, administrator, Mease Hospital and Clinic, P.O. Box 760, Dunedin 33528, phone (813) 733-1111.

ADDITIONAL PHYSICIANS URGENTLY NEEDED: GP, internal medicine, obstetrics, pediatrics, and general surgery. Modern office immediately available. Contact I. B. Price, M.D., P.O. Box 819, Quincy, Florida 32351.

PHYSICIANS WANTED: General practitioner, internist or physician with surgical training, to join six man medical group in metropolitan Miami area. Excellent unlimited earnings opportunity. Percentage with guaranteed minimum. All benefits of group practice. Contact S. L. Weiss, M.D. or Eli Galitz, M.D., 1025 E. 25th St., Hialeah, Florida or (305) 696-0842.

MEDICAL ARTS CENTER: Unique and modern, under construction. Specialty 3-man expansion wing planned. Area needs ENT, internist, ophthalmologist and urologist. Randall B. Whitney, M.D., 408 Highway 19-Alt., Mount Dora, Florida 32757.

MEDICAL DIRECTOR FOR RESPIRATORY CARE UNIT WANTED: For 520 bed accredited community hospital in Hollywood, Florida. Write Dr. Marvin S. Allen, Chief of Staff, Memorial Hospital, 3501 Johnson Street.

EMERGENCY ROOM PHYSICIAN: Needed for St. Petersburg hospital some time after the new year. 42-hour week. Contact H. W. Brown, M.D., 755-19th Ave., N., St. Petersburg, Florida 33704.

situations wanted

POSITION WANTED: GP, 12 years, Florida license, wishes emergency room, industrial, group or clinic on East or West coast. Available July 1972. Elliot Polsky, M.D., 127 Dogwood Rd., West Haven, Conn. 06516. (203) 795-3644.

IMMEDIATELY AVAILABLE: Associate Anesthesiologist or head of anesthesia department. Prefer hospital of about 150-400 beds in coastal community of about 25,000-75,000. F.A.C.A. with 20 years' experience. For mutual exchange of information write C-512, P.O. Box 2411, Jacksonville, Florida 32203.

OBSTETRICIAN-GYNECOLOGIST: Board eligible. Recently university-trained. Military completed. Wishes Southeast or Southwest Florida coastal area. Available spring, 1972. Write C-521, P.O. Box 2411, Jacksonville, Florida 32203.

SITUATION WANTED: 40 year old, active midwestern general practitioner with Florida license desires position or association with either group, private or industrial practice in Miami or nearby Florida areas. Write C-983, P.O. Box 2411, Jacksonville, Florida 32203.

LOCUM TENENS IN ANESTHESIOLOGY: Available for month of February, March or April or part thereof. For mutual exchange of information write C-522, P.O. Box 2411, Jacksonville, Florida 32203.

WANTED: Full time hospital or medical school surgical position, director of surgery, chief of staff, director of medical education, emergency service, intensive care service. Fully qualified in administrative, clinical and teaching surgery, highly desirable, 46 years old. Curriculum vitae on request. Write C-519, P.O. Box 2411, Jacksonville, Florida 32203.

POSITION WANTED: Private surgical practice, associate and assistant. Highly qualified and very desirable but position must not exceed 40 hours/week. Curriculum vitae on request. Write C-520, P.O. Box 2411, Jacksonville, Florida 32203.

PRACTICE DESIRED: Physician (M.D.) with internal medicine background and Florida license desires to purchase an active general practice in Fort Lauderdale. Write C-525, P.O. Box 2411, Jacksonville, Florida 32203.

ORTHOPEDIC PHYSICIAN ASSISTANT STUDENT: Four years navy corpsman. Will have associate in science degree in physician clinical assisting in June. Desires position with surgeon or group. Write Terry Boyle, 12600 Shaker Boulevard, Suite 808, Cleveland, Ohio 44120.

PEDIATRICIAN: 34 year old certified, Florida license, military completed July 1972. Desire group or multispecialty association. Write C-528, P.O. Box 2411, Jacksonville, Florida 32203.

practice available

OB-GYN. PRACTICE, EQUIPMENT AND FURNISHINGS FOR SALE: Located in central area of Coral Gables. Approximately 1,000 sq. ft. consisting of reception room, business office, two examining rooms, laboratory, powder room and consultation room. New lease available. For further information write R. B. Chrisman Jr., M.D., 819 North Greenway Drive, Coral Gables, Florida 33134.

real estate

EXCELLENT OFFICE SPACE AVAILABLE: In the Five Points Medical Center, Oak and Lomax Sts., Jacksonville, Fla. 32204. All utilities and services furnished. For information please call Dr. Max Mendelson at 355-5150.

HOLLYWOOD—SPACE AVAILABLE. New Medical Offices. Will partition. Ideal location—Hollywood Boulevard. Riverside Military Academy Circle. For information call: Dr. Alvin Fisher, 3816 Hollywood Blvd., Hollywood, Florida. Phone (305) 989-9800.

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FOR SALE: 5,500 sq. ft. hollow tile mansion on 21,000 sq. ft. lot. 300 ft. Palm Beach area hospitable Paul Zoeckler, Realtor, 5011 South Dixie, West Palm Beach, Florida 33405. Phone 585-2521.

OCEANFRONT CONDOMINIUM apartments in beautiful Ormond Beach, Florida. The ATLANTIS CONDOMINIUM provides a superb combination of white sand beach, sparkling refreshing ocean, in-town services, shopping conveniences, beautiful building, and excellently planned apartments from $36,740. Attractive financing available. Live-in manager. Preconstruction sales well under way. BEAUTIFUL BUILDING! Every 2 bath, 2 bedroom apartment directly on and facing the ocean. Attractive lounge and recreation rooms. Pool and sunning area. Landscaping. Elevator service to enclosed garage. EXCELLENT LOCATION just a block walk to Granada Ave. with its shops, restaurants, churches, banks, stockbroker, golf, and tennis. Let us prove that we are not overstating the case for this attractive and ideally located condominium. Write or call collect Hayward Brown and Associates, Inc., Realtors, P.O. Box 1627 U, Ormond Beach, Florida 32074. Phone (904) 677-1442.

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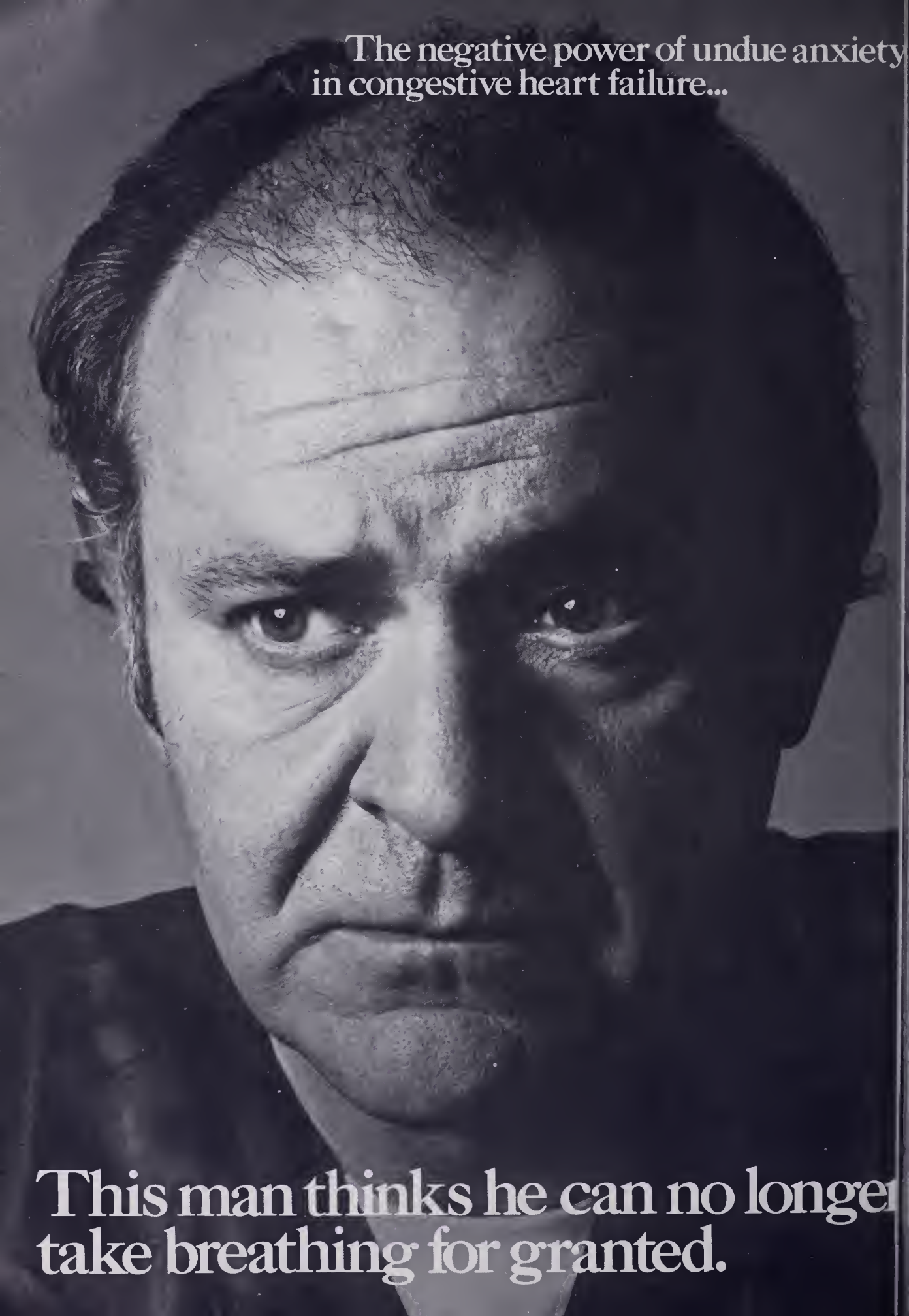
THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

MARCH 1972

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MDS




The negative power of undue anxiety
in congestive heart failure...
This man thinks he can no longe
take breathing for granted.

Typical of many patients with congestive heart failure, he also suffers from severe anxiety, a psychic factor that may influence the character and degree of his symptoms, such as dyspnea. His apprehension may also deprive him of the emotional calm so important in maintenance therapy.

Aid in rehabilitation

Specific medical and environmental measures are often enhanced by the antianxiety action of adjunctive Libritabs (chlordiazepoxide). Libritabs can also facilitate treatment of the tense convalescent patient until antianxiety therapy is no longer required. Whereas in geriatrics the *usual daily dosage* is 5 mg two to four times daily, the *initial dosage* in elderly and debilitated patients should be limited to 10 mg or less per day, adjusting as needed and tolerated.

Concomitant use with primary agents

Libritabs is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics, antihypertensives, vasodilators and oral anticoagulants, whenever excessive anxiety or emotional tension adversely affects the clinical condition or response to therapy. Although clinical studies have not established a cause and effect relationship, physicians should be aware that variable effects on blood coagulation have been reported very rarely in patients receiving oral anticoagulants and chlordiazepoxide HCl.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

The positive power of

Libritabs®

(chlordiazepoxide)

5-mg, 10-mg, 25-mg tablets

t.i.d./q.i.d.

up to 100 mg daily

for severe anxiety accompanying congestive heart failure

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MARCH COVER—We are indebted to Dr. Morton M. Axler of Miami for this photograph of the Anhinga II bird taken in the Everglades National Park. Because this bird lacks certain oils in its feathers for drying, it sits for long periods of time with its wings spread.

President's Page



The Usual, Customary and Reasonable Program

This President's message is directed mainly to those physicians who have entered the state since 1968, and particularly to those who are participating physicians under the Blue Shield contracts which offer "usual, customary and reasonable coverage" to the subscribers.

This program began as the result of action taken by the House of Delegates of the FMA in 1969, wherein they gave approval for the usual and customary program. As many of you are well aware, under the terms of the usual and customary program, physicians receive their usual and customary charge for the service rendered to the subscribers or their dependents. The determination of the allowances under this program will be made in keeping with the Florida Medical Association's definitions of usual and customary. These definitions are:

Usual: *The fee usually charged for a given service by an individual physician to his patient; that is his own usual fee.*

Customary: *A fee is customary when it is within the range of fees usually charged by physicians of similar training and experience for the same service within the same specific area, and limited geographic area. In 1968, the House of Delegates action limits this to mean no smaller than the county size.*

These payments are based on the 90th percentile method, and this method of percentile allowance was explained in a memo dated October 30, 1970, from J. W. Herbert, the President of Blue Shield of Florida.

Today UCR coverage is included in the Florida Blue Shield basic "U" contract; the Federal High Option program; the CHAMPUS program; and the Blue Shield Master Medical contract. In addition, beginning the first of the year the usual, customary and reasonable charges will also be applied to 72,000 Southern Bell and Western Electric employees and their dependents. This coverage requires no deductible from the patient, and provides payment by Blue Shield directly to a participating physician for 80% of the UCR charges covered under the basic contract. As a participating physician you may bill Southern Bell and Western Electric covered patients for the remaining 20%. Of course, under your agreement with Blue Shield as a participant in the UCR program you would not bill the patient for any charges in excess of the UCR allowance.

It is this last statement that I would expressly wish to call to your attention, because unless you so notify the Blue Shield office that you do not wish to participate in this program, you will automatically become a participating physician, and will be required to abide by the terms of this contract.

Space does not permit a careful analysis or debate upon the advantages of participation or nonparticipation, but I would urge all of you to examine this program carefully and decide if and how you wish to be paid for your services.

J. K. Hurst M.D.

Lofty Hemorrhoids

Mr. H.H., 55, high steel construction worker. For several years, other medications provided little or no relief from pain, burning, and itching of internal and external hemorrhoids. Made worse by much heavy lifting which increased pressure in the intrahemorrhoidal plexus.
"It wasn't serious enough," so he procrastinated in consulting a doctor. Was also afraid the doctor might find something really serious. Bright blood appearing in the toilet bowl and on toilet tissue scared him into seeing doctor. However, careful history and examination disclosed internal hemorrhoids.



a typical proctological patient

to help relieve the pain, itching, burning associate with this and similar anorectal conditions

prescribe

Anusol HC® hemorrhoid suppositorie with hydrocortisone acetate

Each suppository contains hydrocortisone acetate 10 mg, bismuth subgallate 2.25%, bismuth resorcin compound 1.75%, benzyl benzoate 1.2%, Peruvian balsam 1.8%, zinc oxide 11.0%, and boric acid 5.0%, plus the following inactive ingredients: bismuth subiodide, calcium phosphate, and color ing in a bland hydrogenated vegetable oil base.

Precaution Prolonged or excessive use o Anusol-HC might produce systemic cortic steroid effects. Symptomatic relief should not delay definitive diagnosis or treatmen

Dosage and Administration Anusol-HC One suppository in the morning and one bedtime for 3 to 6 days or until the inflam- mation subsides. Regular Anusol: One suppository in the morning, one at bedtim and one immediately following each evacuation.

And for long-term patient comfort... recommend Anusol®
hemorrhoidal suppositories
Each suppository contains the ingredients of Anusol-HC without the hydrocortisone.



Warner-Chilcott
Division, Warner-Lambert Company
Morris Plains, New Jersey 07950

Something new in ampicillin therapy: **low cost**

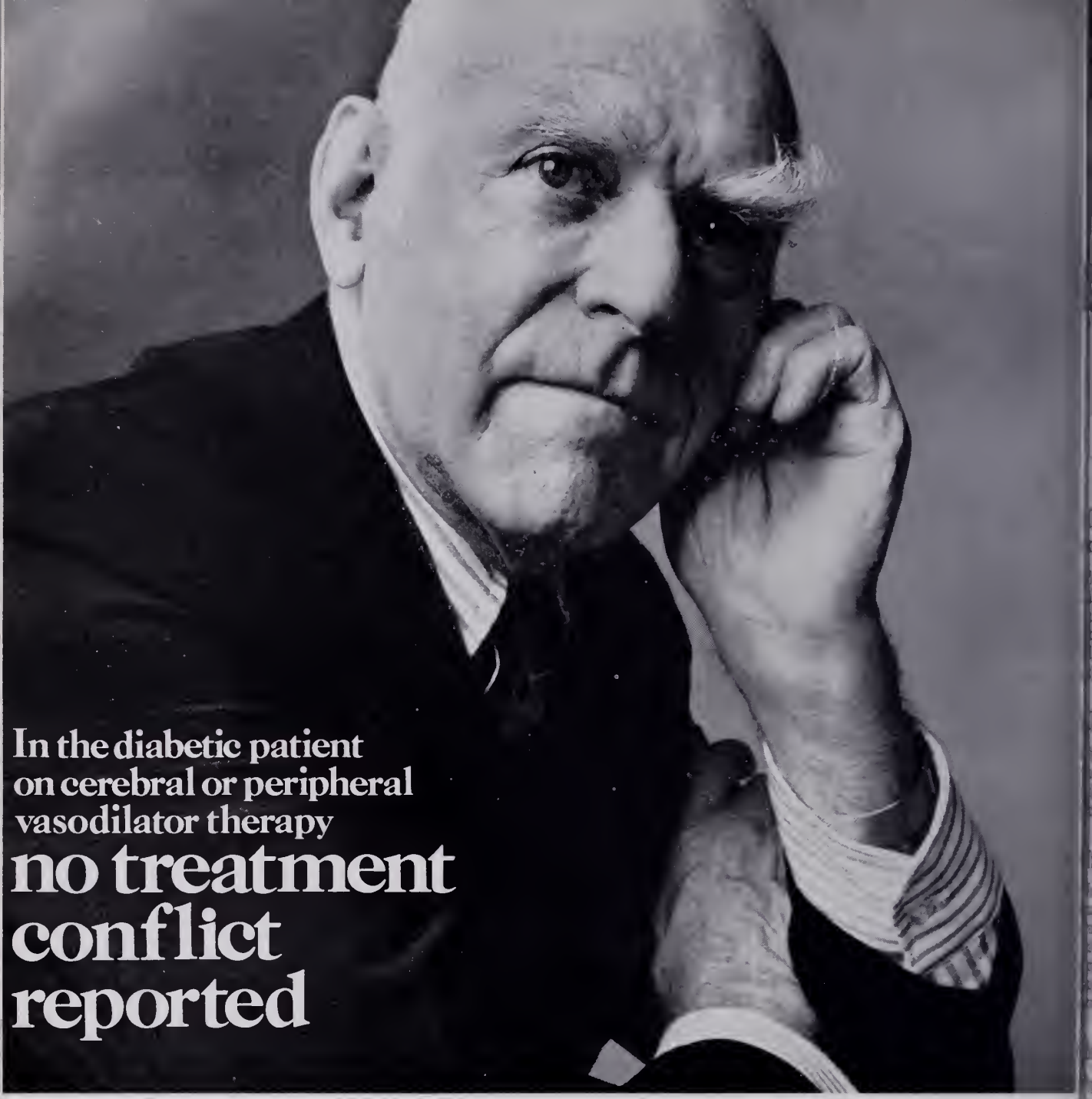


Versapen®-K
POTASSIUM HETACILLIN

the ampicillin derivative

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201



In the diabetic patient on cerebral or peripheral vasodilator therapy

no treatment conflict reported

VASODĪLAN®

(ISOXSUPRINE HCl)

the compatible vasodilator

- no interference with diabetic control . . . does not alter carbohydrate metabolism.[1]
- conflicts have not been reported with diuretics, corticosteroids, antihypertensives or miotics.

There are no known contraindications in recommended oral doses other than it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Although not all clinicians agree on the value of vasodilators in vascular disease, several investigators[2-5] have reported favorably on the effect of isoxsuprine. Effects have been demonstrated both by objective measurement[5,6] and observation of clinical improvement.[2,4]

Indications: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease Raynaud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). **Composition:** VASODĪLAN tablets, isoxsuprine HCl 10 mg. and 20 mg. **Dosage:** Oral—10 to 20 mg. t.i.d. or q.i.d. **Contraindications and Cautions:** There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial bleeding. **Side Effects:** Occasional palpitation and dizziness can usually be controlled by dosage reduction. Complete details available in product brochure from Mead Johnson Laboratories.

References: (1) Samuels, S. S., and Shaftel, H. E.: J. Indiana Med. Ass. *54*:1021-1023 (July) 1961. (2) Clarkson, I. S., and LePere, D. M.: Angiology *11*:190-192 (June) 1960. (3) Horton, G. E., and Johnson, P. C., Jr.: Angiology *15*:70-74 (Feb.) 1964. (4) Dhrymiotis, A. D., and Whittier, J. R.: Curr. Ther. Res. *4*:124-128 (April) 1962. (5) Whittier, J. R.: Angiology *15*:82-87 (Feb.) 1964.

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and Efudex® (fluorouracil) 5% cream can resolve it.

all it actinic, solar or senile keratoses, any regard it as "precancerous."[1,2]

pical fluorouracil, considered by some dermatologists to be a major vance in the treatment of multiple solar keratoses,[3,4] offers the physi- an a relatively inexpensive alternative to cryosurgery, electrodesic- tion and cold knife surgery. Of the topical fluorouracils available, only udex offers 2% and 5% solution and 5% cream formulations—formula- ns that have proved effective in the treatment of these mutliple lesions.

sual duration of therapy, 2 to 4 weeks.

udies showed that with the 2% and 5% Efudex preparations, the usual ration of therapy was only 2 to 4 weeks.[5] Other studies with topical orouracil revealed that when concentrations of less than 2% were ed, significant numbers of lesions recurred.[6]

reats the lesions you can't see, too.

umerous lesions, not apparent prior to 2% and 5% Efudex therapy, anifested themselves by definite reactions, while intervening skin mained relatively unaffected.[5] The early eradication of these subclini- l lesions (which may otherwise have undergone further progression) obably accounts for the reduced incidence of future solar keratoses in tients treated with topical fluorouracil—especially with 5% ncentrations.[6]

ow to identify solar keratoses.

pically, the lesion—a flat or slightly elevated brown to red-brown pule—is dry, rough, adherent and sharply defined. Multiple lesions e the rule.

redictable therapeutic response.

ıe response to a typical course of Efudex therapy is usually aracteristic and predictable. After 3 or 4 days of treatment, erythema gins to appear in the area of keratoses. This is followed by a moderate intense inflammatory response, scaling and occasionally moderate nderness or pain. The height of this response generally occurs two eks after the start of therapy and then begins to subside as treatment stopped. Within two weeks of discontinuing medication, the flammation is usually gone. Lesions that do not respond should biopsied.

ferences: 1. Allen, A. C.: *The Skin, A Clinicopathological Treatise*, ed. 2, New York, une & Stratton, 1967, p. 842. 2. Dillaha, C. J.; Jansen, G. T, and Honeycutt, W. M.: reatment of Actinic Keratoses with Topical Fluorouracil," in Waisman, M. (ed.): *armaceutical Therapeutics in Dermatology*, Springfield, Ill., Charles C Thomas, 1968, 92. 3. Belisario, J. C.: *Cutis, 6*:293, 1970. 4. Sams, W. M.: *Arch. Derm., 97*:14, 1968. Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey. 6. Williams, A. C., and n, E.: *Cancer, 25*:450, 1970.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).



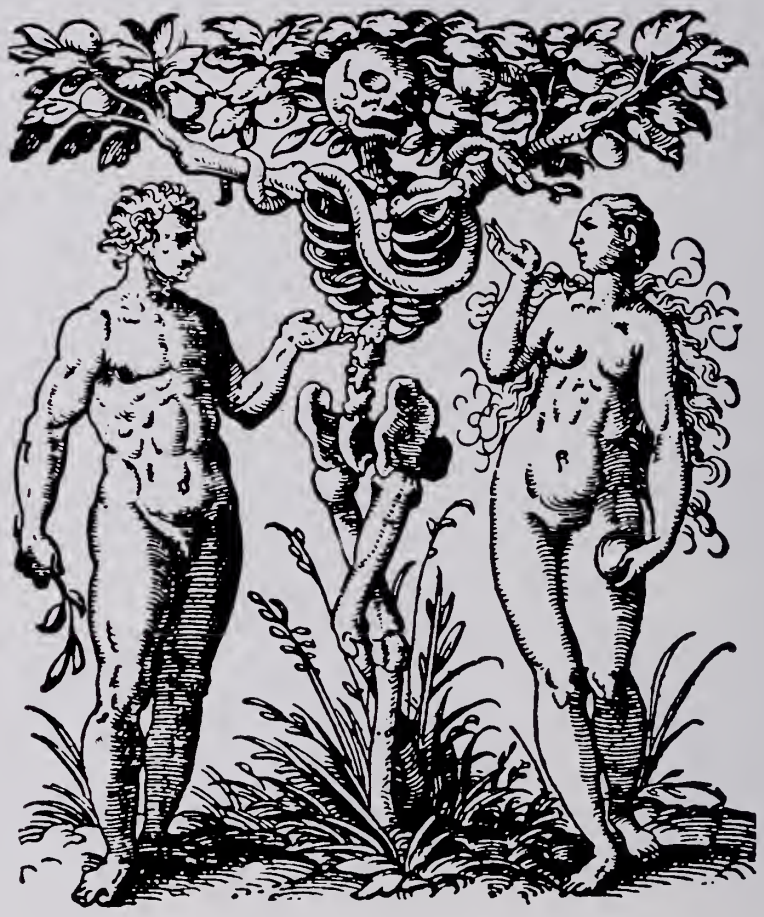
now

Efudex®

(fluorouracil)
cream/solution

In acute gonorrhea

(urethritis, cervicitis, proctitis when due to susceptible strains of N. gonorrhoeae)



Sterile Trobicin®
(spectinomycin dihydrachloride pentahydrate)—For Intramuscular injections, 2 gm vials cantaining 5 ml when reconstituted with diluent. 4 gm vials cantaining 10 ml when recanstituted with diluent.
An aminacyclital antibiotic active *in vitro* against mast strains af *Neisseria ganarrhaeae* (MIC 7.5 to 20 mcg/ml). Definitive *in vitro* studies have shown na crass resistance af *N. ganarrhaeae* between Trobicin and penicillin.

Indications: Acute gonorrheal urethritis and practitis in the male and acute ganarrheal cervicitis and practitis in the female when due ta susceptible strains af *N. ganarrhoeae*.

Contraindications: Cantraindicated in patients previously found hypersensitive ta Trobicin. Nat indicated for the treatment of syphilis.

©1972 The Upjohn Company

Warnings: Antibiotics used to treat gonorrhea may n
delay the symptams of incubating syphilis. Patients sha
carefully examined and monthly serological follow-up
least 3 manths shauld be instituted if the diagnosis of sy
suspected.

*Safety far use in infants, children and pregnant women h
been established.*

Precautions: The usual precautions shauld be observe
atapic individuals. Clinical effectiveness should be monit
detect evidence of develapment of resistance of *N. ganor*

Adverse reactions: The fallawing reactians were ab
during the single-dase clinical trials: soreness at the injecti
urticaria, dizziness, nausea, chills, fever and insomnia.
During multiple-dose subchronic talerance studies in
human valunteers, the fallowing were noted: a decrease ir

Trobicin®

sterile spectinomycin dihydrochloride pentahydrate, Upjohn

single-dose intramuscular treatment

h cure rate:* 96% of 571 males, 95% of 294 females
sages, sites of infection, and criteria for diagnosis and cure are defined below.)**

urance of a single-dose, physician-controlled treatment schedule

allergic reactions occurred in patients with an alleged history of penicillin sensitivity en treated with Trobicin, although penicillin antibody studies were not performed

ive against most strains of Neisseria gonorrhoeae <u>in vitro</u> (M.I.C. 7.5-20 mcg/ml)

ngle two-gram injection produces peak serum concentrations averaging about mcg/ml in one hour (average serum concentrations of 15 mcg/ml present 8 hours after dosing)

e: Antibiotics used in high doses for short periods of time to treat gonorrhea may mask or delay the ptoms of incubating syphilis. Since the treatment of syphilis demands prolonged therapy with any ctive antibiotic, and since Trobicin is not indicated in the treatment of syphilis, patients being treated for orrhea should be closely observed clinically. Monthly serological follow-up for at least 3 months should nstituted if the diagnosis of syphilis is suspected. Trobicin is contraindicated in patients previously found ersensitive to it.

compiled from reports of 14 investigators. **Diagnosis was confirmed by culturol identitication of *N. gonorrhoeae* on Thayer- in media in all patients. Criteria for cure: negative culture after at leost 2 days post-treatment in males and at leost 7 days post- ment in females. Any positive culture obtained post-treatment was considered evidence of treatment failure even though the w-up period might have been less than the periods cited above under "criteria for cure" except when the investigator determined reinfection through additional sexual contacts was likely. Such cases were judged to be reinfections rather than relapses or es. These cases were regarded as non-evaluatable and were not included. JA72 1848-6

n, hematocrit and creatinine clearance; elevation of alka- hosphatase, BUN and SGPT. In single and multiple-dose s in normal volunteers, a reduction in urine output was l. Extensive renal function studies demonstrated no con- t changes indicative of renal toxicity.

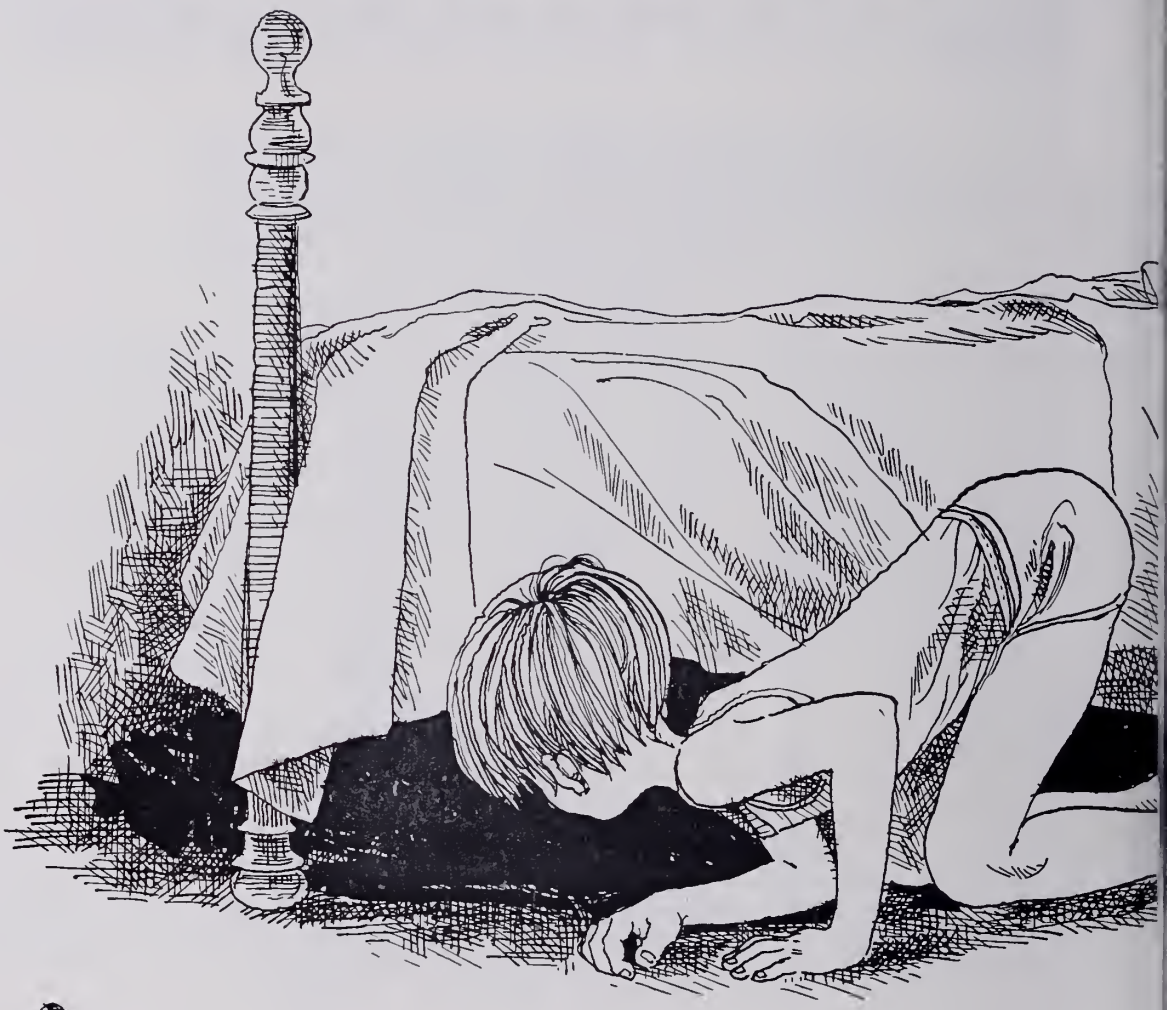
ge and administration: Keep at 25°C and use within urs after reconstitution with diluent.
—single 2 gram dose (5 ml) intramuscularly. Patients with rrheal proctitis ond patients being re-treated after failure evious antibiotic therapy should receive 4 grams (10 ml). In raphic areas where antibiotic resistance is known to be pre- t, initial treatment with 4 grams (10 ml) intramuscularly is rred.
le—single 4 gram dose (10 ml) intramuscularly.

supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injectian with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of spectinomycin dihydrochloride pentahydrate equivalent to 400 mg spectinomycin per ml. For intramuscular use only.
Susceptibility Pawder—for testing *in vitro* susceptibility of *N. gonarrhoeae.*

Human pharmacology: Rapidly absorbed after intramuscular injection. A two-gram injection produces peak serum concentrations averaging about 100 mcg/ml at one hour with 15 mcg/ml at 8 hours. A four-gram injection produces peok serum concentrotions averaging 160 mcg/ml at two hours with 31 mcg/ml at 8 hours.
For additional product information, see your Upjohn representative or consult the package insert. MED-B-1-S (LWB)

Upjohn The Upjohn Company, Kalamazoo, Michigan 49001

Arthur lost





A single-dose, non-staining anthelmin

his pinworms...



with just one non-staining dose of Antiminth (pyrantel pamoate) Oral Suspension.

Highly effective. Active against pinworm...and roundworm.

Non-staining. Doesn't stain teeth or oral mucosa on ingestion. Doesn't stain stools, clothing or linen.

Simple dosage. Single-dose regimen: 1 cc. per 10 lbs. of body weight (1 tsp. per 50 lbs.).

Well-tolerated. Based on pre-introductory studies.

Pleasant-tasting. Easy-to-take, caramel-flavored oral suspension.

Economical. One prescription for the entire family.

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 μg/ml) are reached in 1-3 hours. Ouantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia

Skin reactions: rashes.

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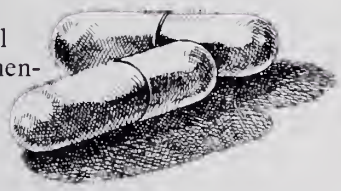
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Medical News

Five New Medical Schools Open

Five new medical schools opened their doors last fall, including the University of South Florida at Tampa.

These schools, plus enlarged classes at other schools, increase first year students to a record high of 11,858, approximately 500 more than last year, according to American Medical News.

The five new medical schools raised the number of U.S. medical schools to 108. At least seven more are expected to open by 1973.

The number of doctors is growing faster than the number of potential patients. At present, the U.S. population is increasing at the rate of about one per cent per year; the physician population is increasing at three per cent per year.

Stroke Conference at Ponte Vedra

The Third Annual Stroke Conference will be held on Saturday, May 20, at the Ponte Vedra Inn, Ponte Vedra.

The Conference—for which the title will be "Rehabilitation of the Stroke Patient"—is sponsored by the JHEP Stroke Study Group and the Regional Medical Programs. Information may be obtained from David F. Scales, M.D., Program Chairman, 2547 St. Johns Ave., Jacksonville, Fla. 32205.

AMA Committees Named

Several Florida residents are involved in recent appointments, reappointments and retirements from committees of the Board of Trustees of the American Medical Association.

Individuals are appointed to Board committees and councils for one year, and the maximum length of service is 10 consecutive terms.

Reappointments included:

Donn L. Smith, M.D., Tampa, to the Council on Drugs; Granville W. Larimore, M.D., of Tampa, to the Council on Environmental and Public Health; Francis C. Coleman, M.D., Tampa, to the Council on Health Manpower; and H. Phillip Hampton, M.D., Tampa, to the Council on Legislation.

Mason Romaine, III, M.D., Jacksonville, to the Council on Voluntary Health Agencies; Roy M. Baker, M.D., Jacksonville, to the Committee on Community Emergency Services; and James W. Walker, M.D., Jacksonville, to the Committee on Nursing.

Retiring from the Committee on Occupational Toxicology was William B. Deichmann, Ph.D., of Miami, while Robert Williams, M.D., Gainesville, was reconfirmed as a member of the Committee on Continuing Professional Education Programs of Voluntary Health Agencies. On the Committee, he represents the National Association for Mental Health, Inc.

William T. Haeck, M.D., Jacksonville, was appointed to the Commission on Emergency Medical Services as a representative of the American College of Emergency Physicians. Reappointed to the Commission as a representative of the American Society of Anesthesiologists was Eugene L. Nagel, M.D., Miami. Wilson T. Sowder, M.D., Jacksonville, retired as an alternate representative of the American Public Health Association.

ACP Admits 11 From Florida

Eleven Florida physicians have been admitted to membership in the American College of Physicians. The latest group of new members numbers 242 United States and Canadian physicians.

New members from Florida are: Howard W. Ramsey, M.D., of Gainesville; Lewis D. Fineman, M.D., and Alan Roberts, M.D., both of Hollywood; Abe Marcadis, M.D., of Lake Worth; Barry J. Materson, M.D., of Miami; Daniel D. Nixon, M.D., of Miami Beach; Mihalj Matko, M.D., and Albert M. Ziffer, M.D., of Orlando; Lee S. Harris, M.D., of Sarasota; William G. Baker Jr., M.D., of St. Petersburg; and Fred A. Guthrie, M.D., of Winter Haven.

Certified in ENT

Edward McDonough, M.D., of Delray Beach, recently was certified by the American Board of Ophthalmology and Otolaryngology.

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Phakomatoses

ROBERT C. KARLSBERG, M.D.

A routine history and physical are adequate diagnostic tools in identifying each of the phakomatoses. This review based on these diagnostic methods is oriented toward the general practitioner, pediatrician, neurologist and internist.

General Characteristics

Phakomatoses may be thought of as disseminated hamartomas; that is, anomalies of tissue formation rather than neoplastic cellular proliferations arising in previously normal tissue. These anomalies of tissue formation need not be present at birth but may manifest themselves at any age in an individual with proper genotype.[1]

The majority of these hamartomas, also referred to as "birth spots" or "mother spots," are hereditary and appear to be of autosomal dominance with variable penetrance. As is characteristic of many heritable diseases, those which are recessive are most severe. Among the phakomatoses, ataxia telangiectasia is the only recessively inherited disease.

Although the size of hamartomas increases with body growth, they rarely become malignant (exception: sarcomatous degeneration in 15% of patients with neurofibromatosis). Pheochromocytomata are found much more frequently in patients with phakomatoses than in a random group of patients.[2]

Phakomatoses may involve only one tissue, as in the Sturge-Weber syndrome where only vascular hamartomas are noted, or they may afflict several tissues, for example, the heart and lung involvement noted in cases of tuberous sclerosis which is primarily a central nervous system disorder.

Classification

The syndromes included under the phakomatoses include:

1. Bourneville's Epiloia (tuberous sclerosis)
2. Louis-Bar Syndrome (ataxia telangiectasia)
3. Sturge-Weber Syndrome (encephalo-trigeminal angiomatosis)
4. Von Hippel-Lindau Syndrome (angiomatosis retinae plus cerebellar hemangioblastoma)
5. Von Recklinghausen's Disease (neurofibromatosis)
6. Wyburn-Mason Syndrome

Bourneville's Epiloia

Bourneville's Epiloia is transmitted as an autosomal dominant with low penetrance. It is estimated that one in 60,000 cases is a mutation. The onset of this disease usually occurs by three years of age and these patients classically die before age 25. However, a number of these cases are *formes frustes*.

From the Department of Ophthalmology, University of Florida College of Medicine, Gainesville.
Supported in part by USPHS Grant EY 00033 from the National Eye Institute.
Reprint requests to H. E. Kaufman, M.D., Department of Ophthalmology University of Florida College of Medicine, Gainesville, Florida 32601.

Skin

The cutaneous findings in Bourneville's Epiloia are subungual fibromas, "adenoma sebaceum" and shagreen patches. "Adenoma sebaceum" is actually a misnomer for angiofibromas which appear in early childhood as numerous, small, reddish, smooth papules on the face in "butterfly distribution." The shagreen patches appear as slightly raised and slightly thickened areas of skin, suggestive of "orange peel skin" and are most characteristically found over the sacrum.

The "ash-leaf" sign detected by use of an ultraviolet light (Wood's lamp) reveals a fluorescent patch of skin which resembles the leaf of an ash tree and is reputed to be pathognomonic of tuberous sclerosis. It is frequently the first sign of the disease and is usually present at birth. Approximately 1 x 3 cm. in size, it may be found anywhere on the body.[3,4]

Viscera

Myocardial manifestations of Bourneville's Epiloia include rhabdomyomata of the heart occasionally causing supraventricular arrhythmias.[5]

Mixed renal angiolipomas occur in 80% of tuberous sclerosis cases and are usually asymptomatic, multiple and bilateral. These tumors, which are rarely malignant, do not require surgery unless symptomatic.

Chest roentgenograms reveal a fine netlike or honeycomb reticulation throughout both lungs similar to changes noted in pulmonary cystic disease. These cysts may result in pneumothorax. Lung involvement often causes death within five years after the onset of pulmonary symptoms.

Nervous System

The majority of patients with Bourneville's Epiloia are not mentally retarded and the nodular intracranial calcification "brain stones" noticed in many of them are in no way associated with mental retardation. These "stones" are most frequently associated with subependymal astrocytic hamartomas. On x-ray these hamartomas appear along the ventricular margins and, regardless of calcification, can be identified pneumoencephalographically.

Skeletal System

In addition to intracranial calcification, dense sclerotic islands in the bones of the cranial vault are valuable roentgen signs. X-rays may reveal cystlike defects in the phalanges and a wavy periosteal calcification along the shafts of the metatarsals and metacarpals.

Eye

The ophthalmic manifestations are most frequently characterized by astrocytic hamartomas of the retina and, occasionally, giant drusen ("tapioca pudding") of the optic nerve head.

As with the astrocytic hamartomas of the retina observed in von Recklinghausen's Disease, the lesions are often peripheral and appear as small, whitish, well-circumscribed nodules which tend to calcify with increasing age.

Louis-Bar Syndrome

The Louis-Bar Syndrome is a familial autosomal recessive disease with progressive cerebellar ataxia and atrophy. The onset is usually in infancy.

Skin

The cutaneous manifestations include telangiectasia especially in the sun-exposed, popliteal, and ante-cubital areas, cafe-au-lait spots, and areas of depigmentation.[6]

Hematopoietic System

There may be a delay between the detectable deficiency of the immunoglobulins (IgE and/or IgA) and the manifestations of this deficiency.[7] The sinopulmonary infections which manifest the immunologic incompetence of these patients is the most common cause of death and gamma globulin (essentially IgG) is not therapeutic. There is also an increased incidence of lymphoid tumors and malignant lymphomas noted in patients with ataxia telangiectasia.[8]

Nervous System

Ataxia develops at about one year of age; a wheelchair is usually necessary by age eleven. Hypoplasia of the cerebellar cells accounts for the choreoathetosis. Pituitary and hypothalamic lesions have been reported and possibly explain the endocrine disorders noted among these patients.

Eye

The ophthalmic manifestations noted in these patients include a peculiar gaze nystagmus known as ocular motor apraxia. In all cases, (noted between the ages of four and six years) a progressive bulbar conjunctival telangiectasia can be seen which later involves the "butterfly area" of the face.

Sturge-Weber Syndrome

The Sturge-Weber Syndrome is characterized by intracranial venous angiomata of the leptomeninges, ipsilateral port-wine nevus, and frequent angiomatous involvement of the eyeball, mouth and nasal mucosa.

In contradistinction to the other phakomatoses, the Sturge-Weber Syndrome is not heritable. Cutaneous angiomas of the trunk and extremities, and hemangiomas of the internal organs (colon, kidneys, lungs) indicate that the Sturge-Weber Syndrome is a generalized angiomatosis.

Skin

Cutaneous manifestations are usually present at birth and become more apparent during early childhood. The skin lesion is usually a unilateral capillary angioma (nevus flammeus; port-wine stain), often in the distribution of the trigeminal nerve, particularly its ophthalmic division. When the ophthalmic division of the trigeminal nerve is involved, the central nervous system is frequently and severely affected. The facial angioma is most frequently on the same side of the body as the intracranial and ocular hemangioma.

Nervous System

The venous angioma of the leptomeninges is homolateral to the skin lesion. It usually involves the posterior pole (occipitoparietal region) of the brain but seldom extends over the midbrain or cerebellum. The angioma tends to become stationary by the end of the second decade of life.

The brain underlying the angioma may show little change in infancy. However, by puberty the cortex is likely to be atrophic, causing convulsions, usually Jacksonian. This atrophic cerebral tissue calcifies and is responsible for characteristic double-contoured linear x-ray opacities. Although calcifications begin in infancy, they are usually not detectable on x-ray until a few years later.

Eye

Glaucoma and angioma of the lids, conjunctiva, iris and choroid are common manifestations. The choroidal angioma is frequently observed near the optic disc and is often surrounded by dilated choroidal vessels. A nonrhegmatogenous retinal detachment with shifting fluid may be observed. Angioma of the choroid may be present without accompanying glaucoma, and a thickened choroid can manifest itself as hyperopia. Angioma of the iris produces a heterochromia iridum.

Von Hippel-Lindau Syndrome

Von Hippel-Lindau Syndrome is inherited as an autosomal dominant with incomplete penetrance. It usually manifests itself in the second and third decades of life with retinal lesions (von Hippel) and cerebellar lesions (Lindau).

Genitourinary

Many of these patients die due to hypernephroma; this renal carcinoma may produce polycythemia which might provide an early clue to its presence. Early radiographic studies are needed to check for asymptomatic renal malignancy. Renal cysts are found, as well as cysts of the ovary and epididymis.

Viscera

Adenomas and cystadenomas of the pancreas are frequently associated with the disease; less frequently noted are cavernous hemangiomas of the liver and cystic angiomas of the lung. In general, these visceral tumors do not exhibit clinical manifestations.

Nervous System

Central nervous system findings of von Hippel disease were noted by Lindau to be present in 25% of patients he examined and consist most frequently of a cerebellar hemangioblastoma, often with a cystic component.

The symptoms of cerebellar involvement are paroxysmal headache particularly associated with exertion or change in position, nystagmus, ataxia and adiodochokinesis. A lesion in the cerebellum, or a hypernephroma, may be a cause of polycythemia.

Brain tumors account for the high mortality rate noted especially in the second and third decades of life. Detection of a small central nervous system lesion should encourage one to perform early surgery, thereby ultimately decreasing the existing high mortality rate.[1]

Skin

Although cutaneous lesions do not frequently occur with this disease as compared to their incidence in the other phakomatoses, the presence of facial cutaneous angiomatous lesions has been noted in a small percentage of cases.

Eye

The ocular hallmark of von Hippel-Lindau Syndrome is angiomatosis retinae, which usually leads to blindness. These lesions present initially

in the peripheral retina as a globular formation (capillary nevus) which is salmon-colored and is connected to a dilated, tortuous vein and a similar artery. Later, this salmon-colored capillary nevus results in retinal hemorrhage, exudate, and in a yellow circinate retinopathy; eventually, secondary gliosis develops, characterized by a yellow-tan ring about the periphery of the retinal hamartoma. At an even later stage in the disease, retinal detachment is noted and, finally, angle closure and phthisis bulbi are seen.

Often there are multiple retinal lesions, which are bilateral in 50% of the cases.[9] Since the retinal angiomas may appear at any age in any member of the family, it is essential that all members of a patient's family be examined by an ophthalmologist at intervals. Similarly, a patient with successful photocoagulation of an incipient lesion must be routinely examined because other lesions are likely to appear.

Von Recklinhausen's Disease

Neurofibromatosis is the most common phakomatosis (one case in about 3,000 births) and owes most of its protean manifestations to the tumors arising from neurilemma of nerves throughout the body. Most of these tumors have a considerable amount of connective tissue, a situation which has led to the term neurofibroma.

The disease is inherited as an autosomal dominant with variable penetrance. Cases with no family history may be accounted for by an apparent mutation rate of approximately one in 10,000. The disease may first be manifest any time between infancy and adulthood, and the process often becomes exacerbated at puberty, during pregnancy, and at the menopause.

The most frequent sites of internal involvement are bone, the central nervous system and pheochrome tissue. Sarcomatous degeneration of the neurofibromata develops in approximately 15% of cases. Children often show endocrine disorders of sexual development and growth, while pheochromocytomata is the most common endocrine disorder in adults.[10]

Skin

The disease is characterized by cafe-au-lait spots, seen in more than 95% of cases, and neurofibromata of the skin. An incidental cafe-au-lait on the torso is an important diagnostic feature among children, as other signs of neurofibromatosis often manifest themselves later.

Other dermatologic findings include fibroma molluscum and plexiform neurofibromata. The former is a fibrous-like tissue, which, although polypoid in external appearance, is so soft in the center that it can be indented. If the upper lid contains plexiform neurofibromata, palpation of that area gives the impression of a "bag of worms" due to the multiple neurofibromatous cords present in what is otherwise a rather fluid mass.

Nervous System

Within the central nervous system, the acoustic, vagus, and optic nerves are most often involved. Peripheral, spinal, sympathetic, or cranial nerves may exhibit hamartoma; neurofibromatous involvement around the renal artery may produce Goldblatt hypertension.

Gliomas of the cerebrum have been noted. Gliomas of the optic nerve or chiasm are noted in 10% of these patients and may produce straightforward proptosis if the optic nerve tumors are contained within the muscle cone. Bilateral optic nerve gliomas are frequent in neurofibromatosis; glial and meningial hyperplasia are an important histologic finding.[3] Within the orbit, plexiform neurofibroma producing proptosis may be noted.

Skeletal System

In or near bone, neurofibromata may cause erosions or subperiosteal cystic lesions. Absence of the greater wing of the sphenoid, resulting in a posterior orbital encephalocele and pulsating exophthalmus, is an almost diagnostic sign.

As a result of softening of the vertebral column, scoliosis and kyphoscoliosis are frequent. A boxlike enlargement of the sella turcica is associated with neurofibromatous involvement of the upper lid.[4] Enlarged optic canals suggest optic nerve glioma.

Eye

Just as the nerves swell in other portions of the patient's body, so they do in the eye and the swollen nerves are manifested by thickening of the corneal and conjunctival nerves, as well as hamartomata in the ocular trabecular meshwork, ciliary body, and uveal tract. Astrocytic hamartomas of the retina, often peripheral, whitish, small, calcified, well-circumscribed nodules, are an important ophthalmoscopic finding. Myelinated nerve fibers are another ophthalmoscopic finding. Congenital glaucoma is common, and is particularly likely to occur with neurofibromatous involvement of the upper lid.

Wyburn-Mason Syndrome

This rare syndrome consists primarily of arteriovenous aneurysms of the retina and similar intracranial formations.

Nervous System

The posterior fossa and midbrain arteriovenous formation may account for trigeminal neuralgia or other cranial nerve or brainstem manifestations. Involvement of the basifrontal area and the sylvian fissure may cause epilepsy, intracranial hemorrhage, hemiplegia or hemianopsia.

Skeletal System

The arteriovenous malformation may also be noted in the ipsilateral maxilla, pterygoid fossa, and mandible, causing severe epistaxis and oral hemorrhage, which may be especially marked after dental extraction.[11]

Eye

Arteriovenous aneurysms of the retina are monocular congenital malformations which may occupy the entire retina or only part of it. Greatly enlarged and tortuous arteries and veins are often so similar in color that they cannot be differentiated. Arteriovenous anastamoses can usually be detected in the midperiphery of the fundus. No spontaneous pulsation of the vessels is detectable.

Arteriovenous malformations in the orbit and optic nerve may produce mild proptosis, bruits, and congestion of the conjunctival vessels.

Summary

All of the phakomatoses leave early clinical signs which can be interpreted through examination of the patient and his family history. Since early diagnosis improves the prognosis, the general practitioner, internist, pediatrician and neurologist are potentially able to save both the sight and life of such patients.

Hopefully, this review will aid clinicians in recognizing the early manifestations of these diseases.

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The Cult That Outsmarted Itself

Eight years after a chiropractic bill passed the New York Legislature, with the enthusiastic support of the chiropractors, the consequences of that law are becoming audible and the sound is strangely like a death rattle.

In the eight years since passage of the bill, and its signing into law by the Governor, not a single new graduate of a school of chiropractic has been licensed to practice in the State of New York!

Philip R. Johnston, acting secretary of the State Board of Chiropractic Examiners, announced earlier that all chiropractors in practice before 1963 have "now had five chances to pass the qualifying examinations." Those who have not yet passed, he warned, "will have to terminate their practices."

The law provides that no new graduate of a school of chiropractic can take the examination required for licensure unless that school has been inspected and approved by the State Education Department. To date, according to a special article distributed by the Buffalo Evening News, "not a single one of the 12 schools of chiropractic in the United States has received that approval."

Thus, in the nation's most populous state, a cult has outsmarted itself.

Reprinted from the November 1971 Alabama Medical Journal.

Immunoelectrophoresis of Human Serum Proteins Application to Clinical Diagnoses

Carlos J. Dominguez, M.D., F.A.C.P., Francisco Civantos, M.D., John Di Bella, M.D., and Arkadi Rywlin, M.D.

Since the original work by Tiselius in 1937,[1] electrophoresis has been commonly used in Laboratory Medicine for the study of plasma proteins. The proteins with antibody function migrate in the beta and gamma positions of the electrophoretogram and are called "immunoglobulins." The application of immunological techniques and particularly "immunoelectrophoresis" to the study of the immunoglobulins has led to the recognition of numerous new clinical syndromes during the past decade. This paper presents our experience with immunoelectrophoretic analysis at Mount Sinai Hospital of Greater Miami during the first nine months of 1970. Some basic concepts necessary for the interpretation of the results will be reviewed briefly.

All immunoglobulin molecules have a similar basic structure consisting of two pairs of polypeptide chains held together by disulfide and hydrogen bonds.[2] Two of the polypeptide chains are designated as "heavy (H)" and the other two as "light (L)" because of their molecular weights (about 50,000 and 23,000 respectively). There are five major antigenic types of "heavy" chains called Gamma, Alpha, Mu, Delta and Epsilon and two types of "light" chains called Kappa (or Type I) and Lambda (or Type II). The heavy chain type determines the immunoglobulin class (Table 1). Immunoglobulins G, A, D and E have a molecular weight between 150,000 and 200,000 and a sedimentation coefficient of 7 to 8 Svedberg units. Molecules of immunoglobulins M ("macroglobulins") are usually aggregates of ten heavy and ten light chains with a molecular weight of 900,000 and a sedimentation coefficient of 19 Svedberg units. Bence Jones proteins are free light chains (not bound to heavy chains) and can therefore be of Kappa or Lambda antigenic type.

Each "clone" of immunocompetent cells (plasmacytes and lymphocytes) has the apparent capacity to produce only one class and type of immunoglobulin molecules. Therefore when immunoglobulins of different classes or types are found to be elevated, the increase is called "polyclonal" because it reflects the activity of several cell clones. Polyclonal hypergammaglobulinemias are associated with acute and chronic inflammatory processes. An increase in immunoglobulin of one class and type is called "monoclonal" and presumably reflects the activity of a single "neoplastic" clone of cells. A classification of monoclonal gammopathies is presented in Table 2.

Materials and Methods

Serum and urine electrophoresis were performed on cellulose acetate membranes with a Beckman microzone apparatus, and the patterns were scanned by a Beckman microzone densitometer.

Immunoelectrophoresis was done using LKB instruments by the method of Grabar and Wil-

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liams[3] following the micromodification technique of Scheidegger[4] (Fig. 1).

Polyvalent antinormal human serum, antisera specific for the heavy chains of the immunoglobulins G and A and antisera to Kappa chains were prepared by rabbit immunization in our laboratory. Antisera specific for IgD and IgE heavy chains were kindly supplied by Dr. Shaul Kochwa, Department of Hematology, Mount Sinai Hospital of New York. Goat antisera to the heavy chains of IgM and Lambda chains were commercially obtained from Hyland Laboratories, Los Angeles, California.

Immunoelectrophoretic analyses were carried out on all sera showing abnormalities on cellulose acetate electrophoresis.

Results and Discussion

During the nine month period, 2,604 protein electrophoretic and 591 immunoelectrophoretic analyses were performed on sera or urines from different patients. A monoclonal gammopathy ("M" component or paraprotein) was found in 44 cases, 25 men and 19 women. Contrary to the generally reported incidence of immunochemical types of "M" components,[5-7] there was a large proportion of patients with IgM paraprotein (12/44) and only two patients with a monoclonal IgA (Fig. 2). The incidence of IgG paraproteinemia (25/44) and of Kappa in relation to Lambda light chains in the monoclonal immunoglobulins (31 and 13 respectively) was, however, in concordance with previous reports. The incidence of light chain (Bence Jones) disease is low in our series probably because a higher index of suspicion is necessary for the diagnosis of this condition. Due to their low molecular weight, Bence Jones proteins are readily filtered through the normal glomerulus and appear in the urine long before they reach a measurable concentration in the serum. Exceptions take place in the unusual situation of tetrameric Bence Jones proteinemia[8] and when coexisting renal disease decreases the plasma

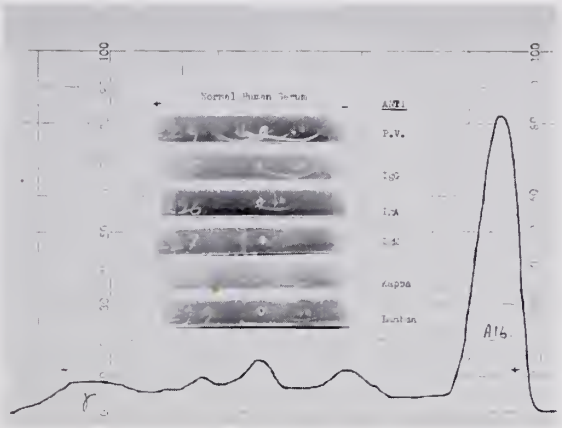


Fig. 1.—Cellulose acetate electrophoretic and immunoelectrophoretic patterns of normal human serum. P.V.: polyvalent antinormal human serum. IgG, IgA, IgM: antisera specific for the heavy chains of immunoglobulins G, A and M. Kappa and Lambda: antisera specific for light chains. The normal IgG population (arrow a) contains light chains of both types (arrows d and e). The concentration of normal IgA (arrow b) is too low for its light chains to produce distinct precipitin arcs. The normal IgM is barely visible (arrow c). Albumin is the heavy arc closest to the anode (arrow f). Testing for IgD and IgE is not done routinely.

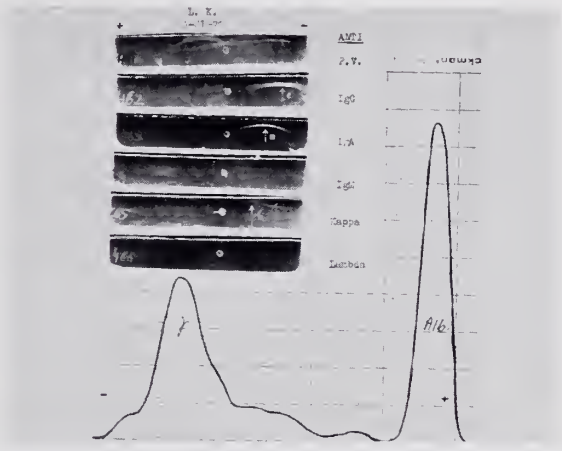


Fig. 2.—Case #10. Monoclonal IgA type Kappa. The marked increase in the concentration of IgA produces a heavy precipitin line (arrow a) and Kappa light chains of the same mobility are distinct (arrow b). No reaction with Lambda antiserum confirms the monoclonal character of the IgA. The normal IgG population is decreased (arrow c).

Table 1.—Nomenclature of Immunoglobulins.

Immunoglobulin Class*	Serum Level (mg.%)	Heavy Chain Type	Light Chain Type
IgG	900-1,500	Gamma	Kappa or Lambda
IgA	140-220	Alpha	Kappa or Lambda
IgM	80-120	Mu	Kappa or Lambda
IgD	3	Delta	Kappa or Lambda
IgE	0.03	Epsilon	Kappa or Lambda

*Ig stands for "Immunoglobulin"

Table 2.—Etiological Classification of Monoclonal Gammopathies.

A. MALIGNANCIES OF THE HEMATOPOIETIC SYSTEM
 a. MULTIPLE MYELOMA
 b. WALDENSTRÖM'S MACROGLOBULINEMIA
 c. FRANKLIN'S HEAVY CHAIN DISEASES
 d. LYMPHOMAS AND MYELOPROLIFERATIVE DISORDERS
B. ASSOCIATED WITH NONLYMPHOPLASMOCYTIC DISORDERS
 a. NEOPLASMS
 b. AUTOIMMUNE DISEASES (SLE, ETC.)
 c. CHRONIC LIVER DISEASES
 d. CHRONIC INFECTIONS
 e. MISCELLANEOUS (GAUCHER'S DISEASE, ETC.)
C. ISOLATED FINDING IN OTHERWISE HEALTHY INDIVIDUAL
 a. "BENIGN" MONOCLONAL GAMMOPATHY

clearance of light chains (Figs. 3A and 3B). In the majority of cases presented in Table 3 "no proteinuria" refers only to a negative qualitative test for protein with the Labstix reagent strip done as part of the routine urinalysis. It is important to recognize that paper-strips impregnated with buffered indicators frequently fail to detect the presence of Bence Jones proteinuria.[9] Urine specimens were not available in five patients (cases 1, 29, 30, 33 and 43).

A diagnosis of multiple myeloma was established in 16 of the 25 patients with IgG paraprotein, the patients with IgA and IgD paraproteins and one of the two patients with light chain disease. Bone marrow specimen was not obtained in case 21. Of the 12 patients with an IgM paraprotein, five had Waldenström's macroglobulinemia, three had a malignant lymphoma of other type, one had carcinoma of the breast, one had pernicious anemia, and no bone marrow studies were available in two (Table 3). The detection of IgM paraproteinemia is of particular importance in elderly patients with generalized arteriosclerosis whose neurological and cardiovascular complaints may be aggravated by serum hyperviscosity.[10]

Of special interest were two patients with two different "M" components in the serum. Biclonal gammopathies have been the subject of several reports in the literature[11-14] the most frequent combination being that of IgG and IgA. Our two patients showed the unusual combination of IgG and IgM. One patient (case 14, Fig. 4) was a 56-year-old woman admitted to the hospital because of pneumonitis. A bone survey disclosed the presence of multiple lytic lesions in the skull and the left scapula. A sternal bone marrow specimen was hypercellular and showed focal collections of plasma cells, lymphocytes and lymphocytoid plasma cells of the kind seen in typical cases of Waldenström's macroglobulinemia. The other patient (case 25) was a 76-year-old man with severe

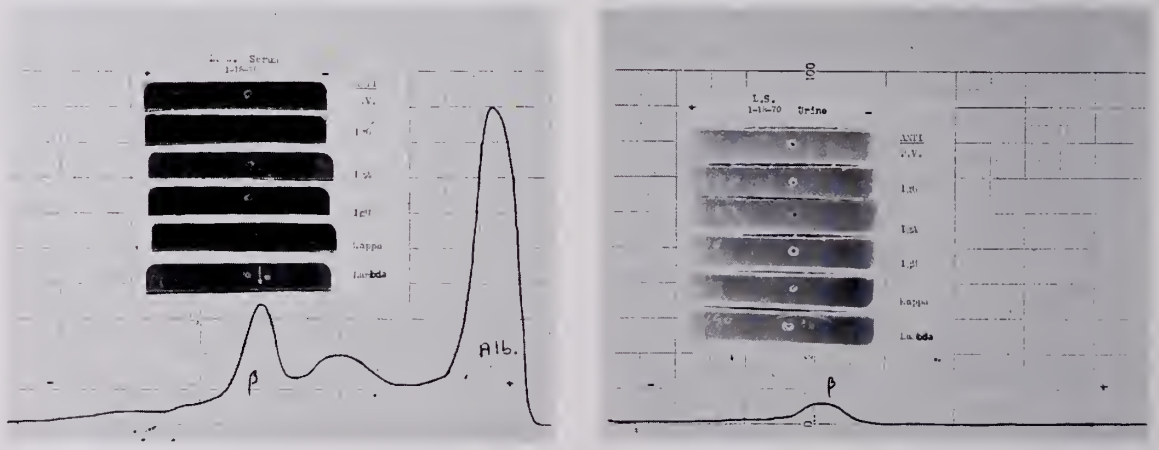


Fig. 3A and 3B. Case #20. Bence Jones protein of Lambda type in serum and urine. A heavy precipitin line of fast mobility is obtained with the Lambda chain antiserum (arrows a and b). The absence of a corresponding precipitation arc with the antisera against heavy chains indicate they are free light chains. Albuminuria is also present (arrow c).

osteoporosis and bone marrow findings typical of multiple myeloma. It is debatable if the presence of a biclonal gammopathy indicates the coexistence of two different neoplastic cell lines in the immunocompetent system. At least in some cases it appears that only one cell line is the origin of the multiple paraproteins.[15]

The incidence of IgD paraprotein among cases of multiple myeloma has been estimated between 1.5% and 2.8%.[16-18] The patient in our series (case 32) presented with hepatosplenomegaly, renal stones and cholelithiasis. The bone marrow was infiltrated with sheets of immature plasma cells. One small area of radiolucency in the right hip was the only demonstrable bone lesion. As in most cases of IgD myeloma, the paraprotein had Lambda light chains, but Bence Jones proteinemia and proteinuria were absent.

The laboratory diagnosis of monoclonal gammopathy is also important because paraproteins are found in patients who do not have histological evidence of multiple myeloma or Waldenström's macroglobulinemia, but who harbor other neoplasms or suffer from conditions characterized by chronic inflammation and immunological aberrations.[19,20] Several of such cases are present in our series (cases 23, 26, 36 and 42). Plasma cell infiltrates of the lymph nodes and connective tissue adjacent to the tumoral masses are presumably the origin of the paraprotein seen in some cases with carcinomas.[21] When a bone marrow plasmocytosis is also present it may be extremely difficult

TABLE 3.—SEROLOGICAL CLASSIFICATION OF CASES WITH MONOCLONAL GAMMOPATHY.

CASE NO.	AGE, RACE, SEX	SERUM	URINE	CLINICAL DIAGNOSES
1.	71 WM	IgG,K; B.J.K.	No specimen	Gaucher's disease
2.	76 WM	IgG,K	No proteinuria*	M. Myeloma
3.	75 WM	IgG,K	No proteinuria*	M. Myeloma
4.	75 WM	IgG,K	Albumin	M. Myeloma
5.	68 WF	IgG,L	Albumin	Subarachnoid hemorrhage
6.	68 WM	IgG,L	Albumin	M. Myeloma
7.	70 WF	IgM,K	No proteinuria*	Waldenström's macrogl.
8.	75 WM	IgM,K	No proteinuria*	Waldenström's macrogl.
9.	61 WF	IgM,L	No proteinuria*	Waldenström's macrogl.
10.	75 WF	IgA,K	No proteinuria	M. Myeloma
11.	65 WM	IgG,K	No proteinuria*	M. Myeloma
12.	74 WF	IgG,K	Albumin, IgG	M. Myeloma
13.	68 WF	IgG,K	No proteinuria	M. Myeloma
14.	56 WF	IgG,K; IgM,K	Albumin, IgG	M. Myeloma and/or Waldenström
15.	65 WM	IgG,K	No proteinuria*	M. Myeloma
16.	69 WM	IgM,K	Albumin	Waldenström's macrogl.
17.	68 WM	IgG,K	No proteinuria	Diabetes mellitus
18.	80 WM	IgG,K	No proteinuria	M. Myeloma
19.	78 WM	IgG,K	Albumin	Paget's disease
20.	64 WF	B.J., L	B.J., L	M. Myeloma
21.	74 WM	B.J., L	B.J., L	Chronic pyelonephritis**
22.	65 WM	IgM,L	No proteinuria*	Lymphocytic lymphoma
23.	70 WM	IgG,K	No proteinuria*	Obstructive uropathy
24.	80 WF	IgG,L	No proteinuria	M. Myeloma
25.	76 WM	IgG,K; IgM,K	No proteinuria*	M. Myeloma
26.	70 WF	IgG,L	No proteinuria*	Rheumat. arthritis, posit. L.E.
27.	59 WF	IgG,K	B.J., K	M. Myeloma
28.	76 WF	IgG,L	No proteinuria*	M. Myeloma
29.	46 WF	IgG,K	No specimen	M. Myeloma
30.	73 WF	IgG,L	No specimen	M. Myeloma
31.	71 WF	IgM,K	Albumin	Malignant lymphoma
32.	68 WM	IgD,L	No proteinuria	M. Myeloma
33.	80 WM	IgG,K	No specimen	M. Myeloma
34.	74 WM	IgG,L	B.J., L	M. Myeloma
35.	55 WF	IgG,K	No proteinuria*	Sickle cell trait
36.	80 WF	IgM,K	No proteinuria*	Ca. of breast
37.	78 WM	IgM,K	No proteinuria*	ASHD**
38.	69 WF	IgM,K	No proteinuria*	Waldenström's macrogl.
39.	62 NM	IgG,K	No proteinuria	Osteoporosis
40.	71 WM	IgM,L	No proteinuria*	No pathological diag.**
41.	51 WM	IgM,K	No proteinuria*	Lymphocytic lymphoma
42.	60 WF	IgM,K	No proteinuria	Pernicious anemia
43.	67 WM	IgA,K	No specimen	M. Myeloma
44.	71 WM	IgG,K	No proteinuria*	M. Myeloma and Ca. of kidney

*on routine urinalysis.

**no bone marrow specimen.

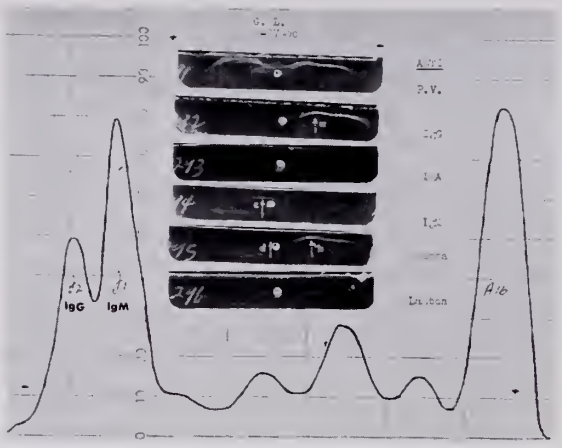


Fig. 4.—Case #14. Biclonal gammopathy: IgG and IgM both with Kappa light chains. The IgG precipitin line shows an abnormal heavy hump in its fast portion (arrow a) which types for Kappa chains only (arrow b). A distinct arc typing only for Kappa chains is also obtained with the IgM antiserum (arrows c and d). Note the corresponding two "spikes" in the cellulose acetate strip.

to differentiate these patients from those who have multiple myeloma and a second coexisting neoplasma.[22,23] One patient in our series had Gaucher's disease, which is associated with a high incidence of immunoglobulin abnormalities.[24]

The incidence of a serum "M" component in the general adult population has been estimated to be approximately 0.9%.[25] When persons above 70 years of age are screened, the incidence may increase to 3%.[26] At the time the paraprotein is discovered the great majority of these subjects do not show any evidence of a malignant process and are classified as having "essential" or "benign" monoclonal gammopathy.[27] Five such cases are present in our series (cases 5, 17, 19, 35 and 39). The literature contains many reports of cases called initially "benign" in which an overt picture of multiple myeloma or Waldenströms macroglobulinemia developed over the course of the years.[28] In fact, based on the information now available on the kinetics of myeloma cells and the synthetic rate of the paraproteins it appears that a period of 20 or more years may elapse before these tumors manifest themselves clinically.[20] Criteria favoring the diagnosis of a "benign" gammopathy are: A nonincreasing paraprotein amount of less than 2 Gm.%, presence of normal amounts of other immunoglobulins, absence of free light chains and less than 10% of plasma cells and lymphocytes in the bone marrow.[19,30] Still, in some cases only a careful follow-up will elucidate the true nature of the diagnosis.

Summary

The experience with immunoelectrophoretic analysis at Mount Sinai Hospital of Greater Miami from January through September 1970 is reviewed. The serological classifications and clinical diagnoses in 44 cases found to have a monoclonal gammopathy are presented. The causes for the low incidence of light chain (Bence Jones) disease in our series and the diagnostic implications of paraproteinemias are discussed.

References are available from the authors upon request.

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New Film Alerts Medical Assistants to the Pitfalls in Medical Offices

Wyeth Laboratories of Philadelphia has produced a new motion picture, "Case in Point," to dramatize the "do's" and "don't's" for the medical assistant while receiving and caring for patients in the physician-employer's office.

Designed primarily to avoid malpractice suits, the film is subtitled "Medico-Legal Responsibilities of the Medical Assistant." In enactments of the "right and wrong way," it deals with such problems as handling emergencies when the physician is away, medication errors, first-aid problems, missing and stolen prescription blanks, and confidential information. The producers recommend the picture for both physicians and their staffs and suggests scheduling it for a "boss's night" program. It is 25 minutes, 16mm, in sound and color, and available on free loan from Wyeth Film Library, Box 8299, Philadelphia, Pennsylvania 19101. "Case in Point" was premiered in October, 1969, at the Honolulu Annual Convention of the American Association of Medical Assistants.

Use of Illegal Drugs in College

W. J. Coggins, M.D. and John F. Scales, B.S.

Considering the widespread interest in drug use and abuse in this country, there have been relatively few well-designed, methodically conducted, statistically valid samples of large population groups to determine the extent of illegal drug use or the abuse of legally prescribed drugs. In one large university in the southeast, impressions among students, administrators and faculty that the use of marijuana and other illegal drugs was increasing rapidly led to this study. Since marijuana seemed to be the most widely used illegal drug, the study focused on it with additional questions raised about use of other legal and illegal drugs.

Method

A simple one sheet questionnaire was designed. A 10% random sample of students enrolled in the university was chosen by picking every tenth name in an alphabetical listing of the student body. Anonymity of response was insured by having those who selected the sample and mailed the questionnaire not otherwise associated with the study. Anonymity of responders was stressed in a letter which accompanied the questionnaire. (Copies of the letter and questionnaire are available upon request.) The questionnaires were mailed in November 1969 and a second identical questionnaire marked "Second Mailing" was mailed two weeks later to the entire sample.

Results

Of 2,028 questionnaires mailed, 1,272 were returned. Of these 945 were from the original mailing and 326 were from the second. The response rate was 62.7%.

In response to the question, "Have you ever tried marijuana?" 385 of the 1,272 (30.3%) responders answered "Yes." Of those users 62 (16.1%) indicated a single use, 108 (28.1%) up to five times, 46 (11.9%) up to ten times, 56 (14.5%) up to 30 times, and 112 (29.1%) more than 30 times. These 112 users represent 8.8% of those responding.

In response to the question regarding current usage 189 of the users (49.1%) indicated that they no longer used marijuana, 82 (21.3%) indicated once a month, 45 (11.7%) once a week, 34 (8.8%) up to three times a week, 10 (2.6%) up to once daily, and 10 (2.6%) more than once

Table 1.—First use of Marijuana.

	Jr. High or High School	Freshman or Sophomore	Junior or Senior	Graduate School	No Answer	Total
Number	73	163	89	39	21	385
Percentage of all Users	18.9	42.3	23.1	10.1	5.5	99.9
Total enrolled in University by Level	—	7,474	8,646	4,084		20,204

daily. Thus 181 (47.0%) users indicated that they still used marijuana. This is 14.2% of those responding. Fifteen students did not answer this question.

To compare current usage with prior usage the students were asked, "Do you use marijuana more, less or the same as six months ago?" Sixty-three (16.4%) of total users reported "more," 138 (35.8%) reported "less," and 104 (27.0%) reported "same." Eighty (20.8%) did not respond to this question.

In response to the question, "In which school year did you first try marijuana?" 4 (1.0%) indicated junior high school, 69 (17.9%) high school, 81 (21.0%) first year college and 82 (21.3%) second year college. Table 1 compared these responses with the numbers and percentages enrolled at the various grade levels.

In response to the question, "Where did you live when you first smoked marijuana?" 205 of the 385 users (53.2%) reported the city in which the college is located, 99 (25.7%) reported this occurred in another city of greater than 50,000 population and 13 (3.4%) reported living in a city of under 50,000 population. Out-of-state residency was indicated by 63 (16.4%).

In asking what factors prevented the student's trying marijuana and what factors caused the student to stop, no choices were supplied. Ample space for write-in answers was provided. The responses of those who had smoked marijuana to the question, "If you no longer use marijuana, why?" are categorized and compared with the responses given by nonusers to the question, "What are the major factors which have prevented your trying marijuana?" Table 2 summarizes these responses.

In comparing the reasons given for quitting marijuana with those given for not starting to use the drug, the most common response by far was simply lack of interest or need for it (52%-56%). The next most frequent reason given for quitting was fear of legal consequences (32.8%). By contrast only 23.5% of the nonusers gave fear of the law as a reason for abstention. One third (33.1%) of the nonusers listed fear of physical or psychological harm to themselves as a reason for abstaining. Some of the students described effects they had personally observed in users which apparently reinforced them in abstaining. Others alluded to information from reading or speakers which impressed them with the potential dangers of marijuana use. Some responders in this group specified fear of addiction or habituation as a reason, while others mentioned fear of physical or psychological ill-effect in a more general way. The next most prevalent response (21.8%) among nonusers was that of religious, personal or parental

TABLE 2.—COMPARISON OF REASONS GIVEN FOR QUITTING MARIJUANA WITH REASONS GIVEN FOR NOT STARTING.

	189 EX-USERS		885 NONUSERS	
	NUMBER	PERCENTAGE	NUMBER	PERCENTAGE
No desire, interest or need	99	52.5	498	56.3
Fear of legal consequences	62	32.8	208	23.5
Fear of physical or psychological harmful effects	36	19.0	293	33.1
Drug not available	27	14.3	183	20.7
Religious, personal or parental disapproval	19	10.0	193	21.8
Peer group doesn't use the drug	12	6.3	44	5.0
Poor health	6	3.2	77	8.7
No answer	2	1.0	11	1.2
Multiple reasons	63	33.3	463	52.3

disapproval as a factor in abstaining. An almost equal percentage (20.7%) gave lack of availability or access to the drug as a reason. These two responses were less prominent in the ex-users, 10% and 14.3%, respectively. The proportion of abstainers listing poor health as a reason for not using (8.7%) more than double that of the ex-users (3.2%) listing this reason. Many of those giving this reason specified respiratory conditions such as asthma as being the prime reason for abstaining. Peer group pressure, which is ordinarily considered a strong modifier of behavior, was listed by only 6.3% of ex-users and 5% of abstainers as a factor. Such group pressure may, in fact, be a much stronger conditioner of the individual's behavior but not be perceived by him as such. It may also be a more important reason for starting drug use rather than stopping.

Less than a third of the responding students in the sampled university had tried marijuana, the most popular of the illegal drugs currently used by young people. About half of those who had used it reported having discontinued the practice Those who have used marijuana more than 30 times constitute 29.1% of the users sampled and it would seem logical to assume that they are the long-term users. Further studies will be needed to ascertain this. Since the drug appears to be harmless biologically, in small dosage and short-term use, the group at risk from the psychological effects and potential long-term biological effects appears to be limited to that 29.1% of users who continue it for weeks or months.

Three fourths (77.8%) of the marijuana users had their first experience with the drug in college but a significant percentage (18.9%) first used it in high school. In this sample first use of the drug is predominantly a phenomenon of the teen years. It remains to be seen whether and to what extent usage becomes a behavior carried on into the early adult years and beyond.

In reporting use of drugs other than marijuana the students were not asked to differentiate between drugs prescribed for them by a physician and those obtained illegally. Thus, some of the responses in Table 3 probably indicate drugs legitimately prescribed and taken.

It can be seen that very small numbers of marijuana users report regular use of other illegal drugs. Only 11 persons in this sample reported using heroin. This would suggest that in the entire student body of 20,000, not more than 100 persons have tried this drug. Only one person reported regular heroin use. This would extrapolate to an incidence rate of 0.05% (1 per 2,000 students) for the entire group. It is interesting that of the 11 students who reported any use of heroin, two denied any use of marijuana.

Table 3.—Use of Other Drugs.

	Marijuana Users & Ex-Users (N = 385)				Marijuana Nonusers (N = 885)			
	Have Used		Regularly Use		Have Used		Regularly Use	
	#	%	#	%	#	%	#	%
Cigarettes	153	39.7	129	33.5	381	43.0	134	15.0
Alcohol	151	39.2	220	57.1	405	45.7	365	41.2
Barbiturates	66	17.1	5	1.2	53	5.9	2	0.2
Dexedrine	150	38.9	28	7.2	107	12.0	3	0.3
Methedrine (Speed)	45	11.6	2	0.5	3	0.3	0	0
LSD	56	14.5	8	2.0	0	0	0	0
Mescaline-Peyote	64	16.6	7	1.8	0	0	0	0
Cocaine	14	3.6	2	0.5	9	1.0	0	0
Heroin	8	2.0	1	0.2	2	0.2	0	0
Opium	36	9.3	1	0.2	1	0.1	0	0
Paregoric	49	12.7	3	0.7	70	7.9	3	0.3
'Freon'	26	6.7	0	0	3	0.3	3	0.3
Glue	19	4.9	1	0.2	5	0.5	0	0
Other*	127	33.0	0	0	27	2.5	0	0

*Amylnitrite, Asthmador, Belladonna, Codeine, Darvon, Demerol, Librium, Morphine, Psilocybin, Romilar, Valium.

A total of 64 students in the sample have taken LSD one or more times. All of them had used marijuana one or more times. Only eight students reported regular use of LSD. Thus, LSD use correlates better with marijuana use than heroin use does.

Of the prescription drugs reported, dextroamphetamine (Dexedrine) was by far the most widely used, by 22.6% of all students in the sample. This confirms the general impression of physicians working with college students. Of the marijuana users 46% reported Dexedrine use as compared with 12.3% of those never using marijuana. Since amphetamines are prescribed only in exceptional circumstances by the University Health Service, we assume that most of this use is of drugs borrowed from friends or purchased from outside sources. It is common practice for students to share this drug during examination periods but illegal purchase of 5 mg. tablets at prices of .50 to $1 per tablet is not unusual. We have seen no students suffering from the effects of long-term continued abuse of Dexedrine, but students come in occasionally with anxiety, sleeplessness and tachycardia resulting from short-term use of this drug.

The overall incidence of 21% for regular use of cigarettes is encouraging. Ten years ago the percentage of college students using cigarettes was considerably higher than this, suggesting that widespread warnings of the dangers of tobacco do have some impact. Laws prohibiting the purchase of tobacco products by minors have remained unchanged and unenforced during this time. It seems clear that marijuana use does not significantly reduce cigarette smoking since 33% of the marijuana users were regular cigarette smokers, compared with 15% of the non-marijuana users.

Of the marijuana users, 57% report regular use of alcohol as compared with 41% of the non-marijuana users. Students arguing for reduced societal control of marijuana often pose the hypothetical argument of its "safety" as compared with alcohol. This study shows that despite this argument, use of the two drugs is certainly not a mutually exclusive phenomenon. We note further that student use of alcohol as reported here is less common than in American society generally.

In comparing this study with other recent attempts to ascertain the use of marijuana, one study of a large sample of college students in Florida revealed an overall use of marijuana of 27%.* In another setting, samples from seven colleges in New York City revealed a usage rate of 30%.* Further studies are planned to determine what changes, if any, are occurring in the incidence of use of illegal drugs by college students.

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*Personal communication.

Physician Liable for Blood Loss After Biopsy

A patient who suffered bleeding after a biopsy won a suit against a gastroenterologist and a clinic for negligence in performing the procedure and in "coverage" following it. An award of $25,000 was handed down by a California jury.

The patient, a 36-year-old teamster, suffered bleeding from the site of a rectal valve biopsy performed by the gastroenterologist.

As a result of the blood loss, complete cardiovascular collapse occurred, which was relieved by transfusions. The physician denied negligence and insisted that the bleeding was from preexistent ulcerative colitis. — *Hatam v. Babb* (Cal. Super.Ct., Santa Clara Co., Docket No. 214055, 1970)

Reprinted from The Citation prepared by the Law Department, American Medical Association.

Piperacetazine in Chronic Schizophrenia

Henry J. Climo, M.D.,† and Bernice Billett, B.S.

The advent of chlorpromazine hydrochloride in 1954 brought new hope to mental patients. It returned to a useful life thousands of individuals who otherwise would have been confined in psychiatric institutions.

Following chlorpromazine, came other phenothiazines, minor tranquilizers and antidepressants to help control the mentally disabled. These important agents stopped the increase in the population of mental hospitals. Although the number of admissions continued to grow, fewer and fewer patients needed to be retained for prolonged periods. As the number of psychotherapeutic drugs increased, some authorities began to believe there were "too many" drugs designed for mental illness —particularly phenothiazines.

This attitude was effectively rebutted when Dr. Frank Ayd, speaking before a government committee, stated: "Despite all the psychoactive drugs on hand, there are in and outside of mental hospitals thousands of patients either partially or totally refractory to these drugs or intolerant of them. For these unfortunate, suffering individuals, there is an urgent need for more psychoactive drugs. Those who would limit the number of psychoactive drugs also ignore what every psychiatrist experienced in testing and using these drugs knows, namely that some patients benefit only from one compound and are unresponsive to, or are intolerant of, all other drugs. Thus, for the patient who responds to a particular tranquilizer or antidepressant—old or new—that one drug is invaluable."[1]

When a new major tranquilizer, piperacetazine, first came to the attention of our staff, a trial of this phenothiazine derivative was felt to be highly desirable. Although the chemical structure and the specific indications put it in the same category as several excellent phenothiazines already used, there was the possibility that piperacetazine might enable one or more patients who had not adequately responded to other drugs to return to society.

We decided to put this new phenothiazine to a relatively severe test in a preliminary study to evaluate its potential for our standard program of therapy. Our study was limited to patients who had not adequately responded to other drugs or to multiple drug therapy. It was felt that the medication would be proved a valuable agent for routine use if improvement could be demonstrated in 40% of a study group composed of chronic schizophrenics.

Materials and Methods

Ten male patients were selected for a 12 week study. Nine had a diagnosis of chronic schizophrenia and one mental retardation with psychosis. Current treatment included phenothiazines and antiparkinson drugs in all ten patients. There had been no noticeable improvement in their conditions for three to six months.

During a two week crossover for this project, previous medications were reduced and piperacetazine* dosage was increased in increments of 10 mg. every four to five days. At the beginning of the test, 40 mg. of piperacetazine, alone, was being given daily. As with most psychoactive drugs, piperacetazine dosage must be individualized to the patient's response, and for this reason no rigid schedule for increasing dosage was established a priori. No other phenothiazines were given during the study. Drugs permitted, when needed, were chloral hydrate for sleeplessness, sodium amytal for restlessness or aggressive behavior, and antiparkinson medication for the control of extrapyramidal symptoms.

Laboratory tests, including CBC, routine urine and SGPT, were done immediately prior to the study and at four weeks and at 12 weeks.

†Dr. Climo was Senior Investigator (Deceased August 23, 1971). Miss Billett is Project Coordinator, Training and Research Department, South Florida State Hospital, Hollywood.

*Supplied as Quide® by the Dow Chemical Company.

Blood pressure and pulse were measured daily during the crossover and weekly thereafter. Weights were taken weekly.

Clinical evaluations were recorded at least biweekly by the principal investigator, using the Psychiatric Illness Rating Scale for evaluation. Side effects were recorded weekly. Ward behavior was noted on the Burdock, Crane scale by the ward aide.

Results

In the second week of the study (two weeks after completing the crossover) there appeared to be a slightly encouraging change in several patients. We realized that this could be attributed to the possible stimulus of a new drug regimen, although the showing of any enthusiasm in this regard had been conscientiously avoided.

In the sixth week, however, there were definite signs of progress. Remission of several patients' previous condition could no longer be questioned. For example, most of the patients had ceased to be a problem on the ward; previously, they had been so agitated, disoriented or confused that they could not participate in industrial therapy assignments and were inaccessible for any form of psychotherapy.

As improvement occurred, industrial therapy assignments were made available to the men and various restrictions lifted.

As the project continued, it became obvious that piperacetazine was producing positive results, something that other phenothiazines had not accomplished over a period of many months.

During the course of the project, one patient developed a low-grade pneumonia. He was drop-

Table 1.—Results of Piperacetazine Therapy in Chronic Schizophrenic Patients.

Pt.No.	Medication		Symptomatology	Piperacetazine Maintenance Dose	Response to Therapy
1	chlorpromazine conc. trifluoperazine conc. benztropine mesylate	600 mg. 15 mg. 2 mg.	Delusional, bizarre behavior, paranoid	—	Dropped—illness
2	chlorpromazine tab. trifluoperazine tab. imipramine tab. benztropine mesylate	600 mg. 15 mg. 150 mg. 2 mg.	Looseness of association, depressed, talked of suicide	75 mg.	Excellent
3	chlorpromazine conc. trifluoperazine conc. perphenazine conc. benztropine mesylate	600 mg. 40 mg. 12 mg. 2 mg.	Threatened to kill, tried to molest younger sister, used vile language, wandered about naked	100 mg.	Excellent
4	chlorpromazine conc. trifluoperazine conc. perphenazine conc. thioridazine conc. benztropine mesylate	800 mg. 30 mg. 48 mg. 800 mg. 2 mg.	Hallucinations, paranoid, violent	200 mg.	Failure
5	chlorpromazine tab. trifluoperazine tab. amitriptyline tab. benztropine mesylate	900 mg. 20 mg. 150 mg. 2 mg.	Violent, threatened mother, paranoid, hallucinations, looseness of association	60 mg.	Excellent
6	trifluoperazine conc. perphenazine conc. benztropine mesylate	15 mg. 24 mg. 2 mg.	Mentally retarded, unresponsive	150 mg.	Good
7	chlorpromazine conc. benztropine mesylate	600 mg. 2 mg.	Phlegmatic, indifferent, paranoid	100 mg.	Excellent
8	chlorpromazine conc. trifluoperazine conc. fluphenazine Hcl. conc. benztropine mesylate	1000 mg. 40 mg. 12 mg. 2 mg.	Delusional, incoherent, childish behavior	100 mg.	Excellent
9	perphenazine conc. benztropine mesylate	48 mg. 2 mg.	Hallucinations, paranoid, phlegmatic	100 mg.	Excellent
10	chlorpromazine conc. trifluoperazine conc. perphenazine conc. fluphenazine Hcl. conc. benztropine mesylate	900 mg. 40 mg. 36 mg. 2 mg. 2 mg.	Delusional, mildly paranoid	75 mg.	Good (benztropine mesylate continued)

ped from the study and transferred to the medical ward for treatment. Of the nine patients completing the study, one regressed and piperacetazine was discontinued. The remaining eight patients showed good to excellent results, with piperacetazine being the only psychotropic agent employed. The changes in their condition and the maintenance therapy are noted in Table 1. Three were discharged after this study and four more are scheduled for competency interviews. Two case histories are representative of the patients in this project.

Report of Cases

Case 1.—A 22-year-old Caucasian male was admitted January 29, 1969 as a transfer from a Fort Lauderdale hospital (Patient #2). The tentative diagnosis on admission was schizophrenia, latent.

At transfer, the commitment papers described the patient as confused and, at times, violent. He was being treated with chlorpromazine 600 mg., trifluoperazine concentrate 10 mg., imipramine 150 mg. and benztropine maleate 2 mg. daily. His medical history included the fact that he had been struck by an automobile while riding a bicycle in 1961 and had suffered a compressed fracture. It was believed that his mental condition could possibly be related to this injury and that his neurological condition should be evaluated. The neurological examination was essentially normal. Since there was no organic basis for the patient's behavior, treatment thereafter was strictly for psychiatric purposes, and the diagnosis of schizophrenia was confirmed.

Prior to the piperacetazine study, the patient's behavior was unpredictable. At times he would be pleasant and cooperative. On other occasions he would show looseness of association or become exceedingly depressed and talk of suicide. Various measures to reintegrate his ego were taken, including industrial therapy assignments and group participation in the day-care center; none seemed to help.

Medication appeared to be maintaining the patient on a plateau; he did not regress, but his behavior did not improve. Since he was already experiencing extrapyramidal symptoms, it was believed that phenothiazine dosage could not be significantly increased without the probability of severe side effects and adverse reactions.

He started taking piperacetazine on November 11, 1969. By December 2, almost immediately after the crossover, the change in the patient was remarkable. He was friendly, showed no depression, and had stopped expressing self-castigatory remarks accompanied by expressions of guilt. Piperacetazine dosage was progressively increased from an initial 40 mg. daily until, by December 16, he was receiving 100 mg. daily. On January 6, 1970, this was reduced to 75 mg. daily and on this maintenance dose, his excellent state of remission continued.

Comment: This individual, for whom little hope was held because of the severity of his schizophrenia and the near disintegration of his ego structure, was fully reintegrated. He was completely free of his psychosis and became an eager, pleasant, cooperative, normal individual. Approximately five weeks after the conclusion of this study he was granted a competency discharge and released from this hospital for vocational rehabilitation.

Case 2.—A 51-year-old Caucasian male was admitted July 2, 1969 by order of the Dade County Court (Patient #8). He had been in a state hospital in New York between 1966 and 1968 and in another institution between 1948 and 1960. The patient's condition was diagnosed as schizophrenia, chronic undifferentiated.

In the admitting interview the patient stated that he had arrived in Florida about two months before looking for employment. He had been arrested, but could not give the reason or the date; he believed he had spent about seven weeks in the Dade County jail. He was aware he had been in other institutions but could recall no details concerning them.

On admission he appeared confused, was grossly delusional and admitted having auditory hallucinations. He described himself as the luckiest man in the world, the finest composer, and the Commander-in-Chief of the Spanish Armada. He was preoccupied religiously. He said that he was "Aladdin 40" and that his father was "Aladdin 39"—he explained that this gave him greater powers than his father. He admitted to moderate use of alcohol and had used hard drugs and marijuana but denied addiction to them. He rambled incoherently in many of his answers.

Initially, this patient was started on chlorpromazine concentrate 300 mg. and trifluoperazine concentrate 6 mg. daily. Benztropine mesylate 2 mg. daily was added later. Medication was adjusted upward and 6 mg. fluphenazine HCl concentrate daily was also given. His daily dosages prior to this study are shown in Table 1. This dosage regimen, maintained for about two months, had kept the patient on a plateau where there was neither progress nor regression. He was, to some degree, more clear mentally but he was in no position to be considered for release from the hospital. He was delusional, often childish in behavior, and would pace up and down the ward almost continuously.

During his hospitalization the patient had bilateral direct inguinal hernias. He was transferred to the surgical ward and passed through an uneventful surgical procedure and convalescence, although his psychotic state remained the same. It was decided to proceed with the crossover to piperacetazine and he was taking 60 mg. daily when he returned to the psychiatric ward. Dosage was progressively increased every four or five days until it reached 125 mg. daily. This was subsequently reduced to 100 mg.

As this patient's dose of piperacetazine increased, his delusions and childishness tended to disappear. He became brighter, friendlier, and more amenable to efforts expended in his behalf. The pacing had diminished but had not stopped. When this was brought to his attention, he said this was the only exercise available to him. He was then offered an industrial therapy assignment in the car wash, which permitted him to earn money to achieve his stated intention of returning to his family in Puerto Rico.

This patient showed no signs of regression at the end of the study and was transferred to an open ward where he adjusted remarkably well.

Comment: Following the study, the patient continued to show no signs of regression and it is felt that he was receiving a therapeutic, stabilizing dose of piperacetazine of 100 mg. daily. He was an eager, hard worker in the car wash and earned more than enough to return to Puerto Rico. He was granted a competency discharge in June, 1970—a particularly gratifying circumstance in view of his poor response to his previous treatment regimen.

Discussion

The results in this preliminary study were admittedly unexpected, but nonetheless very gratifying to all the staff who participated in the project. The benefits to the patients and to society are obvious. We were particularly impressed that it was not necessary for us to exceed the recommended dosage for piperacetazine. In addition, prior to this study all nine patients had needed an antiparkinson drug to control extrapyramidal symptoms. Excluding the one failure, only one patient managed with piperacetazine needed to continue

his antiparkinson agent. There were no important side effects.

The economic benefits for a state-supported institution are obvious when one psychotropic agent can replace three or four and, certainly, administration is more convenient for the patient and staff. The reduction of the need for antiparkinson drugs is also an economic advantage over the long-term, as well as being of particular benefit to the patient insofar as decreasing potential drug toxicity. The return of these patients to society lessens the financial burden on the community and enables the psychiatric team to give more attention to those who need it.

This project was regarded as beneficial to all concerned, particularly to the staff, because it reemphasized the importance of employing every available tool in the rehabilitation of patients and the need to regard any new psychotropic agent as potentially useful. We now recognize piperacetazine as a valuable agent for use in new admissions as well as those not adequately responding to current therapy.

Summary

Ten mental patients, nine of them chronic schizophrenics, who had not responded satisfactorily to multiple therapy of potent psychotropic agents were placed on piperacetazine, alone, for a period of 12 weeks. The condition of one patient worsened, one was dropped for medical reasons, two showed good improvement, and six had excellent results. In seven patients, the previous extrapyramidal side effects disappeared and only one patient required continued antiparkinson medication. This preliminary study indicates that piperacetazine may be an important addition to the armamentarium of psychotropic drugs.

Acknowledgments

Our thanks go to individual and ancillary personnel: Margaret Linkenheimer, Ward Coordinator; Sarah Woods, R.N., Nursing Supervisor; Gloria Margoles, B.A., Chemist; Evelyn Salerno, B.S., R.Ph., Drug Control.

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Diet Pill Damages Awarded Against Physician and Drug Company

A woman who claimed permanent injury after taking weight-reducing pills prescribed by a physician was awarded $100,000 in damages by a California jury.

A 45-year-old nurse with a history of weight problems went to the physician, who prescribed diet pills. Allegedly as a result of taking the pills, she experienced brain damage, peripheral neuritis, and central nervous system changes. Electroencephalographic findings were abnormal. She claimed that she had residuals of chronic weakness and recurrence of avitaminosis and that she would never be able to work full-time again.

The patient contended that the physician was negligent in giving her too high a dose of the drugs for too long a time and in failing to make proper tests and discover developing problems. She further contended that the drug company was negligent in labeling and selling the drugs, which she said were not safe.

The physician stated that he had employed a recognized form of treatment. In other medical testimony, physicians stated that the brain damage was transitory and not caused by the diet drugs and that there was no heart damage. They also stated that there was a minor residual of a beriberi-like syndrome. It was further contended that the patient went on a crash diet without informing her physician and that her problems were not caused by the pills. — *Bentley v. Vincent* (Cal.Super.Ct., Los Angeles Co., Docket No. LASC 911759, 1970)

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Cirrhosis of the Liver

James E. Fulghum, M.D.

Cirrhosis of the liver is a serious disease which, in recent years, has been increasing in incidence. It currently ranks as the fifth cause of death in Florida at midlife; more than half the deaths (728) occurring at ages 45-64.

In 1969 there were about 1,200 deaths from cirrhosis of the liver in Florida, with an overall mortality rate of 18.8 per 100,000. At ages 45-64, however, the mortality rate from this disease has doubled over the past 8-year period going from 28.4 in 1962 to 56 per 100,000 in 1969. In this age group, the males of both the black and white races have higher mortality from the disease than do the females (Table 1). The whites are somewhat more at risk than the blacks in the age 45-64 group.

The causes of cirrhosis of the liver are unknown, or obscure in many cases. There is evidence that acute hepatitis rarely leads to cirrhosis of the liver, but chronic hepatitis has been implicated. Dietary deficiencies, disease of the bile ducts and chemical toxins are considered by some authorities to be contributory factors in the etiology of cirrhosis of the liver. Alcoholism is mentioned frequently, and in Florida alcohol is noted on about 33% of the death certificates when cause of death was given as cirrhosis of the liver. Recent studies have stressed the importance of alcohol itself as a toxic agent to the liver even when diets are normal and adequate. Many alcoholics do not develop cirrhosis and many cirrhosis of the liver patients are nonalcoholics.

Despite the differences in etiology, the clinical picture is much the same. Even with the improvement of therapeutic modalities, some authorities predict only about a five-year survival rate. Other authorities have been encouraged in the early discontinuance of alcohol, when this seems to be a factor, and when it is possible.

Control of this disease seems limited in that there are little known preventative methods (other than the avoidance of alcohol) and no screening examinations which will specifically identify early cirrhosis of the liver.

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Table 1.—Death Rate* from Cirrhosis of Liver at Midlife, by Sex —Florida, 1962-1969.

	1962	1963	1964	1965	1966	1967	1968	1969
MALE								
45-64	40.5	40.9	42.5	30.8	34.6	35.2	57.6	70.3
45-54	37.3	34.3	36.0	25.2	29.6	33.5	51.8	56.1
55-64	44.4	49.0	50.6	37.6	40.8	37.5	64.6	87.3
FEMALE								
45-64	22.6	23.8	26.7	19.9	18.4	20.0	35.7	43.3
45-54	26.9	25.9	28.4	18.8	19.2	23.2	34.1	42.3
55-64	17.7	21.5	24.8	21.0	17.4	16.4	37.4	44.3

*Rate per 100,000 population

Seventy Millimeter Surveys in Florida

Marianne B. McEuen, M.D., Lawrence C. Manni, M.D.
and Dwight J. Wharton, M.D.

Use of the 70 mm. x-ray unit in mass screening for tuberculosis is no longer favored generally; the yield simply is not good enough. This type of survey was discontinued in Florida in 1960. The unit, however, has considerable value when used selectively among known or suspected high incidence groups. In 1970 from 163,500 films, 112 active cases of tuberculosis were found or one case in 1,460 films. Still being evaluated are 141 patients and based upon previous experiences the disease will be diagnosed in some ten or 12 of them.*

Careful follow-up is necessary to the finding of tuberculosis. In 1970, 98.3% of patients suspected of having the disease were followed as a result of rapid film processing and interpretation and the efforts of local health department personnel who have the problem of locating migrants, tourists and other seasonal residents. Suspicious films usually are reported to the local health department within 48 hours.

The worth of a survey depends upon the number of cases detected. Lichtenstein stated that the finding of one case in 5,000 films makes it worthwhile.[1] In Wisconsin only one case in 20,000 films was found in 1970.[2] Among certain population groups, particularly those associated with children, a low yield may be important. Other factors which must be considered in evaluating a survey include cost, extent of disease at discovery, rediscovery of cases lost to follow-up, and the finding of reactivation and nontuberculous abnormalities. We consider our survey worthwhile on the basis of approximately 50 cents per film or $600 per case, number of cases found, and minimal x-ray exposure of the population.

For purposes of analysis our survey may be divided into three categories: high incidence areas, institutions, and general population groups such as health card applicants.

In high incidence areas one unknown case was found for each 572 films and one case in 1,730 films from persons confined in prisons, training schools and mental institutions. The ratio for the general population was one case in 3,996 films. Since many of these individuals are x-rayed each year, this yield is surprisingly large.

One of the benefits derived from a survey is detection of disease in an earlier stage. This held true despite the more advanced disease found in migrants. Of cases found by survey, 31% were minimal, but only 19% of all reported cases in the state were minimal.

Reporting Other Abnormalities

In addition to tuberculosis, 626 suspected tumors, 1,580 cardiovascular abnormalities and 5,400 other conditions were reported to the county health departments in 1970. The benefits from reporting these nontuberculous conditions are difficult to ascertain. It is useless unless the patient obtains new or changed treatment beneficial to him.

To evaluate this reporting, we attempted to follow-up all abnormalities reported in two counties in 1970. Martin County was considered a high incidence area mostly of field workers and migrant laborers. The Citrus County survey involved principally teachers and health card applicants.

A state mobile unit took 2,014 films in Citrus County and 32 abnormalities were detected. Eight

Presented at the Florida Thoracic Society meeting in Tampa, April 16, 1971.

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*Actually since our 1970 statistics were completed, five of there 141 patients have had a diagnosis of active tuberculosis established making 117 cases or one in 1,390 films.

were suspicious of tuberculosis, six of tumor, seven of cardiovascular abnormalities, and 11 other pathology. In the tuberculosis group three patients were known inactive cases, four new suspects, and metastatic carcinoma was later diagnosed in the other.

Among patients with indication of tumor, one died within a month following diagnosis of bronchogenic carcinoma. One bronchogenic carcinoma has been resected without evidence of metastases. One patient is being treated for lymphosarcoma and currently is well. One neurofibroma has been resected; the patient is well and has returned to teaching. In two patients the abnormalities were considered insignificant.

Of the patients found to have cardiovascular abnormalities, one required hospitalization and two required treatment. Two already were receiving treatment and two required no treatment.

Four of the patients with miscellaneous pathological conditions required no treatment. One required surgical treatment and one medical treatment. Follow-up was not requested for four patients—two with thoracotomies with clear lung fields, one pacemaker and one situs inversus. Evaluation of the remaining patient proved normal in follow-up.

The survey in Martin County revealed 48 abnormal films among a total of 2,823. Suspicion of tuberculosis accounted for 25, tumor two, cardiovascular abnormalities four, and other pathology 17.

Seven tuberculosis suspects were unknown active cases, five known inactive cases, four known suspects, two new suspects, and one a resectable asymptomatic bronchogenic carcinoma. Six were determined nontuberculous and therefore insignificant to the evaluation.

The tumor suspects included a patient with known granuloma and one with known substernal goiter.

The patients with cardiovascular abnormalities included one needing treatment for congestive failure, two receiving care, and a 92-year-old woman with a large heart who had not consulted her physician but feels well.

One patient in the group with other pathological conditions required treatment for a hiatal hernia, six required no treatment and were known to their physicians, three were receiving treatment, further tests revealed no abnormalities in one, and follow-up could not be obtained on one. It was not requested for five.

In these counties from 4,837 films, 18 significant treatable previously unknown abnormalities were found, or an incidence of one in 270 films. Among them were seven active cases of tuberculosis, two resectable bronchogenic carcinomas, one resectable neurofibroma, one lymphosarcoma, four cardiovascular conditions and three other conditions needing treatment.

Conclusion

We believe our 70 mm. x-ray surveys are efficient tuberculosis case detection tools. Additionally a significant number of other abnormalities are found. The number of treatable malignancies discovered in a two-county sample suggests that a statewide follow-up of patients suspected of having tumors may be of considerable value.

The authors wish to express their appreciation to the nursing and clerical personnel of the Citrus and Martin County Health Departments for their help in this study.

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Dean's Page

Shortening The Education Of The Physician
The Three Year Medical Curriculum

Emanuel Suter, M.D.

The view has been expressed in many publications that increasing the number of physicians will solve most problems of health care delivery, and similarly that shortening the medical curriculum will magically increase the number of physicians. No lesser authority than the Carnegie Commission on Higher Education has fallen victim to this trap of logic and arithmetic.*

Nevertheless, shortening the medical school curriculum has become a popular idea in professional and lay circles. Of particular attractiveness is the unfounded prospect that it costs less to educate a physician in a three year than a four year curriculum. This neglects the fact that medical faculties have many other responsibilities in addition to teaching medical students. A recent survey of 108 U.S. medical schools shows that 26 schools have introduced curricula permitting a student to receive the M.D. degree three years after acceptance into the program. In only six of these schools, however, is the three year curriculum the standard program, while in the other 20 schools it is an option offered to especially gifted and competent students.

Debate over the length of the medical curriculum has overemphasized the process of (or time spent in) education rather than focused on the result of this process; thus, while the three phases of medical education (preprofessional, undergraduate, and graduate) presently are stated in terms of years, they should be defined in terms of educational objectives. With such an educational system the faculty would need to measure individually the progress of a student and determine his or her advancement from one phase to another. Some students then would reach the objectives in nine years instead of the standard twelve, while others might take longer. This system requires the collaboration of undergraduate and medical schools and of specialty boards—a difficult but not impossible task.

The faculty of the College of Medicine is well aware of the opportunities in medical education and has developed new programs to permit greater flexibility in progression by the student. Of particular interest are the new programs of articulation between preprofessional and medical education both within the University of Florida and through the program in the basic medical sciences at FSU-FAMU. Also holding much promise is a trial program which substitutes an internship equivalency for the fourth year of medical school and projects into the undergraduate curriculum a portion of those experiences leading to specialty board certification. Faculty and students are collaborating closely in these programs.

No one should expect such changes to be easy or attained cheaply. Curriculum changes are expensive in terms of faculty time, educational facilities and materials. If planned well and implemented by a competent faculty, however, many advantages will accrue on a long term basis. Some of these are: streamlining and improvement of the educational process, higher student motivation and satisfaction, and improved quality of the end product (the practicing physician). Since the "complete physician" no longer is the goal, it is imperative the program develop in the student the capacity and life-long motivation for learning.

These changes produce some major hazards, particularly if they are pressed too hard and implemented without careful planning and a competent faculty. A particular threat to the quality of education is the simultaneous shortening of the curriculum and expansion of the class without adequate increase in faculty and other resources. This real threat of double overload in the system may result in a dangerous drop of quality, and even interruption of the educational process. Organized medicine must follow these developments and insist that a high level of professional competency remain the objective of the educational program for physicians. It also must urge that methods be developed for evaluating the quality of medicine practiced by their graduates.

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*In actuality a sustained increase in the number of graduates must be achieved only through an increase in the number of students in the freshman class. The three year curriculum produces an increased number of graduates only for the one year in which the three year and the four year curricula overlap.

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Warnings: *Drug Dependence:* Physical and psychological dependence and abuse have occurred. Chronic intoxication, from prolonged use and usually greater than recommended doses, leads to ataxia, slurred speech, vertigo. Carefully supervise dose and amounts prescribed, and avoid prolonged use, especially in alcoholics and addiction-prone persons. Sudden withdrawal after prolonged and excessive use may precipitate recurrence of pre-existing symptoms (e.g., anxiety, anorexia, insomnia) or withdrawal reactions (e.g., vomiting, ataxia, tremors, muscle twitching, confusional states, hallucinosis; rarely convulsive seizures, more likely in persons with CNS damage or pre-existent or latent convulsive disorders). Therefore, reduce dosage gradually (1-2 weeks) or substitute a short-acting barbiturate, than gradually withdraw. *Potentially Hazardous Tasks:* Driving a motor vehicle or operating machinery. *Additive Effects:* Possible additive effects between meprobamate, alcohol, and other CNS depressants or psychotropic drugs. *Pregnancy and Lactation:* Safe use not established; weigh potential benefits against potential hazards in pregnancy, nursing mothers, or women of childbearing potential. Animal data at five times the maximum recommended human dose show reduction in litter size due to resorption. Meprobamate appears in umbilical cord blood at or near maternal plasma levels, and in breast milk at levels 2-4 times that of maternal plasma. *Children Under Six:* Drug not recommended.

Precautions: To avoid oversedation, use lowest effective dose, particularly in elderly and/or debilitated patients. Consider possibility of suicide attempts; dispense least amount of drug feasible at any one time. To avoid excess accumulation, use caution in patients with compromised liver or kidney function. Meprobamate may precipitate seizures in epileptics.

Adverse Reactions: *Central Nervous System:* Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity. *Gastrointestinal:* Nausea, vomiting, diarrhea. *Cardiovascular:* Palpitations, tachycardia, various forms of arrhythmia, transient ECG changes, syncope; also, hypotensive crises (including one fatal case). *Allergic or Idiosyncratic:* Usually after 1-4 doses. Milder reactions: itchy, urticarial, or erythematous maculopapular rash (generalized or confined to groin). Others: leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross reaction to carisoprodol, and cross sensitivity between meprobamate/mebutamate and meprobamate/carbromal. More severe, rare hypersensitivity: hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria, anuria, anaphylaxis, erythema multiforme, exfoliative dermatitis, stomatitis, proctitis, Stevens-Johnson syndrome; bullous dermatitis (one fatal case after meprobamate plus prednisolone). Stop drug, treat symptomatically (e.g., possible use of epinephrine, antihistamines, and in severe cases corticosteroids). *Hematologic:* Agranulocytosis and aplastic anemia (rarely fatal), but no causal relationship established. Rarely, thrombocytopenic purpura. *Other:* Exacerbation of porphyric symptoms.

Usual Adult Dosage: 1200 to 1600 mg daily, in three or four divided doses; doses above 2400 mg daily not recommended.

Overdosage: Suicidal attempts with meprobamate, alone or with alcohol or other CNS depressants or psychotropic drugs, have produced drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse, and death. Empty stomach, treat symptomatically; cautiously give respiratory assistance, CNS stimulants, pressor agents as needed. Meprobamate is metabolized in the liver and excreted by the kidney. Diuresis and dialysis have been used successfully. Carefully monitor urinary output; avoid overhydration; observe for possible relapse due to incomplete gastric emptying and delayed absorption.

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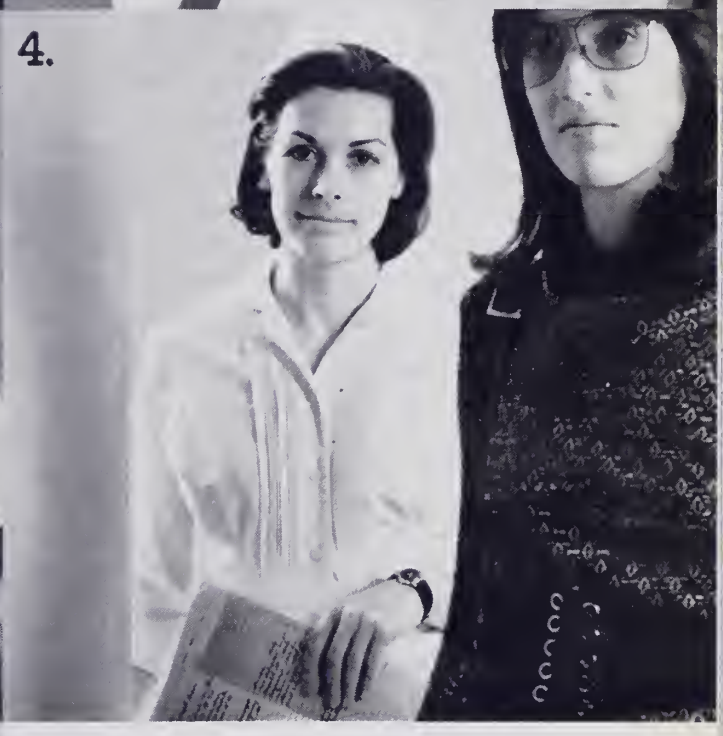
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Editorials

Editor's Breakfast

A far cry from similar conferences nine or 10 years ago was the Fourteenth Annual Conference of County Medical Society Presidents and Secretaries held January 29-30 in Orlando.

Greeted by lovely officers of our FMA auxiliary, each participant was given a handbook describing the responsibilities of county societies and outlining the organizational structure of the FMA, its House of Delegates, the Board of Governors, the 9 councils, various committees and a brief description of its many programs.

On the agenda for the day were such subjects as Peer Medical Utilization Review, Blue Shield, the 1972 Relative Value Studies, Physician's Assistants, Drug Abuse and Continuing Medical Education. As the day wore on, articulate speakers who are dedicated committee chairmen produced facts that would relieve many misunderstandings, quell some complaints and build more support for organized medicine in this state. These have been compiled and can be read in part on page 49. Lack of space and time prevent complete reproduction of all the discussion but manuscripts, when available, were pilfered from the authors and will appear in future issues of *The Journal.*

Not appearing on the program a breakfast meeting was arranged by *The Journal* on the postulate that "Reading maketh a full man, conference a ready man and writing an exact man." Attended by our President, President-Elect, Editors, members of *The Journal* Consulting Editorial Staff and Dr. John Talbott, Editor Emeritus of JAMA, the purpose of the meeting was to determine how *The Journal* could best serve Florida physicians.

Among such questions as, What to publish?, and, How to interest the biggest cross section of our readers, and, How does one persuade physicians to read their state Journal?, one subject that propagated no end of discussion was how could *The Journal* perform to reach Florida medical students. Following a recommendation that we mail a Journal each month to each medical student in the state, the question arose, "How many people are we talking about?" and, "How much money will this cost?" Someone then asked, "Are the students just as bogged down in reading material as private practitioners, and, if so, would the venture be worth the trouble and expense?" To this question, several present who are directly involved in teaching were very certain that the students would be impressed with such a gesture. Others suggested a special students' issue composed of scientific papers submitted by them, a special section or page each month devoted to students, and sending *The Journal* once a quarter or once a year instead of monthly. One participant suggested that county societies finance the sending of Journals to students from their region. Another suggestion was that we give a copy of *The Journal* to each person taking the state medical licensure exams. To a suggestion that it would cost less to persuade the AMA to mail its American Medical News to each student, the reply was that our Journal would more nearly bridge the student-practitioner gap, afford the students a sounding board, sow seeds to germinate into new editorial staff members and indicate concern on the part of organized medicine.

Among the many discussed aspects of writing for, editing and publishing our Journal each month, including the problem of tailoring the original material so that its total cost does not exceed our revenue, it appeared prophetic that the topic usurping most of the time was that of involving medical sudents in affairs that will affect them throughout their entire professional life.

C.M.C.

Come and Go Surgery

With comprehensive health insurance in the offing, of interest to surgeons, hospital administrators and health planning council members is an outpatient clinic for surgery in Phoenix, Arizona called Surgicenter. A locale for some 5,000 walk-in, walk-out operations that otherwise would be performed in hospitals at a much higher cost, estimates are that 20 to 40 per cent of operations now performed in general hospitals could be handled by counterparts of Surgicenter.

Should national health care come into being such a concept appears a necessity because of the tremendous demand that would be placed on all hospitals. Staffed by nine fulltime registered nurses and two fulltime secretary-receptionists, the Arizona clinic is manned by two anesthesiologists who mortgaged themselves to finance the new organization. The 5,000 patients treated so far have undergone some 40 different types of operations. There have been no deaths. The procedure most frequently performed is the diagnostic D&C. No therapeutic abortions have been done but laparoscopy with tubal ligation is increasing in frequency. Cataract operations, inguinal herniorrhaphies (mostly on children) and cystoscopy, which costs $95.00 compared to a local general hospital's charge of $312.00 are procedures frequently done. Not included are professional fees for the surgeon or anesthesiologist. Having obtained approval by Arizona Blue Cross and from a hundred commercial health insurance carriers, they have the official blessing of the AMA, the local county medical society and the comprehensive health planning council of that county but so far HEW has turned thumbs down on paying for Medicare patients.

Avoided is the heavy overhead that acute care hospitals must pay for around the clock staffing for nursing services, laboratory and x-ray procedures needed in overnight patient care. Relieved of postoperative rounds, laborious chart-keeping and extensive records, surgeons give less pre and postoperative medication, since going home is an important psychological step toward recovery. The family's contribution in caring for the patient at home releases nursing personnel while the family is spared the wear and tear of trips to the hospital to visit the patient.

A major conserver of professional time, this new concept permits the doctor to perform with the least interference from administrative red tape.

C.M.C.

The following invocational prayer was delivered by the Chaplain of the Duval County Medical Society and Editor of the Journal, at the Jacksonville Sesquicentennial meeting of the Duval County Medical Society, Tuesday, February 1, and was sent to us by Dr. Emmet F. Ferguson, Jacksonville, with the request we publish it in the Journal.

Almighty God, Thou who hast mercifully and patiently led this society, appointed to watch over the life and health of our community for more than a hundred years; who hast inspired such of our members as Steele, Baldwin and Daniel to actively work as leaders in our city government; who hast walked beside and given ear to the prayers of Francis P. Wellford, as he laid down his life to attend yellow fever patients; and Thou who has allowed us to witness the extermination of such dreadful diseases as smallpox, diphtheria, pneumonia and in our time, polio, we ask Thy blessing on us assembled here tonight.

We pray for a society so deep and universal that it shall gather all practitioners within one fold without regard as to race, creed, politics or social standing. Let our ears hear the cry of the needy and our hearts feel the love of the unlovely. Let our service each day to our patients be a privilege, rather than a sacrifice.

We are grateful for this society, realizing that the wider the span, the longer the continuity, the greater has been the sense of duty in individual members, each contributing their brief life's work to the preservation and progress of the city in which we lived, this society of which they were members and in this profession of which they were servants.

And, so as we continue to live and work in this second century of our society, may we individually aspire each day to succeed, live well, laugh often, love much, gain the respect of intelligent men and the love of little children and leave the world a bit better than we found it. May we never lack appreciation of the beauty around us nor fail to express it and always look for the best in others while giving to others the best in ourselves, so that in a sense, our lives may be an inspiration and our memory, a benediction. Amen.

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14 years ago, you had to rely on our experience.

An orally active hypoglycemic agent principally indicated in relatively mild, adult, maturity-onset, non-ketotic diabetes; also, as a supplement to insulin therapy in selected diabetic patients, it may effect a stabilization of labile diabetes and reduce insulin requirements. Certain patients intolerant to chlorpropamide therapy at usual therapeutic doses have subsequently been successfully managed with Orinase (tolbutamide).

Use in mild asymptomatic diabetic patients with abnormal glucose tolerance tests not responding to diet therapy may result in improvement of the glucose tolerance test.

Use in conjunction with phenformin is indicated when optimal control is not obtained with Orinase or phenformin alone.

Contraindications: Orinase alone is not effective in juvenile or growth-onset diabetes nor in unstable brittle diabetes where insulin therapy is required.

Orinase should not be used: when diabetes is complicated by acidosis, ketosis, or coma, or when a history of repeated bouts of acidosis or coma is obtained; in the presence of other acute complications such as fever, severe trauma, or infections; and in patients with severe renal insufficiency. Insulin is indicated in these circumstances.

Pregnancy Warning: The safety and usefulness of Orinase during pregnancy has not been established either from the standpoint of the mother or the fetus. Animal studies have demonstrated feticidal and teratogenic effects of doses of 1,000-2,500 mg./kg./day, but application to human subjects unknown. Therefore, Orinase is not recommended for the pregnant diabetic, and when administering Orinase to women of childbearing age, these facts should be borne in mind.

Precautions: Diagnostic and therapeutic measures necessar for optimal control with insulin are also necessary with Orinase The patient on Orinase must be fully instructed: about th nature of his disease; how to prevent and detect complications how to control his condition; not to neglect dietary restrictions develop a careless attitude or disregard instructions relative t body weight, exercise, personal hygiene, and avoidance of in fection; how to recognize and counteract impending hypogly cemia; how and when to test for glycosuria and ketonuria; hov to use insulin; and to report to the physician immediately if h does not feel as well as usual.

Caution, very close observation, and careful adjustment o dose are necessary when: insulin is withdrawn during the tria period in order to avoid ketosis, acidosis, and coma; thiazid diuretics are administered which may result in aggravation o diabetic state and increased tolbutamide requirement, tempo rary loss of control, or even secondary failure; treating patient with impaired hepatic and/or renal function and debilitated, mal nourished, or semistarved patients in order to avoid severe hypo glycemia which may require corrective therapy over severa days; and treating patients with severe trauma, infection, or sur gical procedures where temporary return to insulin or additio of insulin may be necessary. Response to tolbutamide is dimin ished in patients receiving therapy with beta blocking agents

As some diabetics are not suitable candidates, it is essentia that the physician familiarize himself with the indications, limit of application, and selection of patients for therapy.

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an daily, and during the first month report at least once weekly r physical examination and definitive evaluation. After a month, aminations are recommended monthly or as indicated. Ap- arance of ketonuria, increase in glycosuria, unsatisfactory wering or persistent elevation of blood sugar, or failure to tain and hold clinical improvement indicate nonresponsive- ss to Orinase (tolbutamide). Orinase does not obviate need for aintaining standard diet regulation. Uncooperative patients ould be considered unsuitable for therapy. Prescriptions should refilled only on specific instruction of physician. In treating ld asymptomatic diabetic patients with abnormal glucose lerance, glucose tolerance tests should be obtained at three- six-month intervals. Orinase is not an oral insulin or a substi- te for insulin and must not be used as sole therapy in juvenile abetes or in diabetes complicated by acidosis or coma where sulin is indispensable.

If phenformin is prescribed in combination with Orinase, ap- opriate package literature should be consulted.

Adverse Reactions: Severe hypoglycemia, though uncommon, ay occur and may mimic acute neurologic disorders such as erebral thrombosis. Certain factors such as hepatic and renal sease, malnutrition, advanced age, alcohol ingestion, and lrenal and pituitary insufficiency may predispose to hypogly- mia and certain drugs such as insulin, phenformin, sulfona- ides, oxyphenbutazone, salicylates, probenecid, monamine idase inhibitors, phenylbutazone, bishydroxycoumarin, and henyramidol may prolong or enhance the action of Orinase and crease risk of hypoglycemia. Orinase long-term therapy has en reported to cause reduction in RAI uptake without producing clinical hypothyroidism or thyroid enlargement and at high doses is mildly goitrogenic in animals. Photosensitivity reactions, disulfiram-like reactions after alcohol ingestion, and false-positive tests for urine albumin have been reported.

Although usually not serious, gastrointestinal disturbances (nausea, epigastric fullness, and heartburn) and headache appear to be dose related and frequently disappear with reduction of dose or administration with meals. Allergic skin reactions (pruritus, erythema, urticaria, and morbilliform or maculopapular eruptions) are transient, usually not serious, and frequently disappear with continued administration. Orinase should be discontinued if skin reactions persist. Recent reports indicate that long-term use of Orinase has no appreciable effect on body weight.

Orinase appears to be remarkably free from gross clinical toxicity: crystalluria or other renal abnormalities have not been observed; incidence of liver dysfunction is remarkably low and jaundice has been rare and cleared readily on discontinuation of drug (carcinoma of the pancreas or other biliary obstruction should be ruled out in persistent jaundice); leukopenia; agranulocytosis; thrombocytopenia; hemolytic anemia; aplastic anemia; pancytopenia; and hepatic porphyria and porphyria cutanea tarda have been reported.

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Indications: Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (*i.e.*, several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.

Contraindications: Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.

Warnings: When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.

Drug Dependence: Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.

Usage In Pregnancy: The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.

Usage In Children: Not recommended for use in children under 12 years of age.

Precautions: In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorexic agent and a restrictive dietary regimen.

Adverse Reactions: Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.

Dosage and Administration: The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.

Overdosage: Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.

Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

How Supplied: Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.

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ORGANIZATION

Fourteenth Annual FMA Conference of County Medical Society Presidents and Secretaries and Seminar on Medical Legislation January 29-30, 1972

Attracting more than 140 FMA and component medical society officers, as well as representatives of the Woman's Auxiliary to FMA and association-recognized specialty groups representing 95% of the FMA membership, a most informative conference was conducted by dedicated physician committee chairmen who knew their subjects and eloquently demonstrated this by keeping their audience alert and interested.

Introductory remarks by Floyd K. Hurt, M.D., FMA President, set the mood for the day.

James L. Borland Jr., M.D., of Jacksonville, chairman of both the FMA Ad Hoc Committee on Health Maintenance Organizations and the Subcommittee on Foundations for Medical Care, proceeded to give a comprehensive discussion of the differences between HMOs and Foundations for Medical Care, saying that HMOs and Foundations have some characteristics in common, including cost and quality control and means for estimating costs of care in advance. Almost every Foundation is sponsored by a county medical society, whereas an HMO may be set up by anyone. A push to clear the way for HMOs in Florida, in removing state legal barriers to their formation, is the subject of several bills filed with the House and Senate. As envisioned by health planners, HMOs would employ closed panel groups of physicians, operate on a prepayment plan with open enrollment on a first come-first served basis, and have strong consumer representation on policy and peer review boards. Each HMO would serve from 20,000-50,000 up to 200,000 persons and physicians would be expected to participate in risk sharing. Dr. Borland expressed grave concern that if profit-making HMOs are allowed, there will be a great incentive for under-utilization. Foundation supporters recognize the need for patient protection believing that physicians should police their own actions. Minimum standards of service are prescribed while the fee-for-service principle of payment is supported.

At a luncheon hosted by FMA, Ernest B. Howard, M.D., Executive Vice President of the American Medical Association, brought his audience up to date on the national medical scene, declaring that the subject of HMOs is a beautiful PR (public relations) gambit for politicians, but that at the present time there are no HMOs in this country. A number of grants have been distributed, however, while the AMA is referring to this concept as "contract practice (HMO)," he estimated that there are only 5,000 physicians in the U.S. working on salary in group practice arrangements, a miniscule thing in this country. Looking into his crystal ball, Dr. Howard predicted that Rep. Wilbur Mills' House Ways and Means Committee will report out a national health insurance bill acceptable to the House. What it will be is anyone's guess, he stated, but it will not embrace the Kennedy approach which has little favor in the Ways and Means Committee.

Dr. Howard forecast greater federal input into the Medicaid program, and that the AMA opposes any free-standing proposal for catastrophic coverage. Whatever the House passes will be a very modest bill with minor disruption of the present system, but the Senate's disposition is uncertain. He quoted the staff of the Price Commission as saying that rules applying to medical fees will be extended to the fees of lawyers, architects and other professionals in the near future.

He spoke at length on the fee-for-service principle as being a sound principle which must be preserved despite the attacks by liberal health planners. He described the organization of a new Liaison Committee on Graduate Medical Education on approval of the Board of Trustees. He said there will be no AMA dues increase in the near future but that the AMA will live within a balanced budget, and develop an accelerated membership recruitment program. He called for unity within the AMA and said ways must be found to

give medical specialties a greater decision-making role in the AMA as well as integrating hospital medical staffs into county medical societies.

The afternoon session was ably monitored by President-Elect Bill Dean who displayed a mature grasp of medical affairs.

George S. Palmer, M.D., of Tallahassee, Executive Director of the Florida State Board of Medical Examiners, gave a factual report on the current activities of the Board, announcing that 2,095 new physicians were licensed in Florida during 1971, an all-time high, topping the 1,759 licensed in 1970. Approximately 15,700 physicians now hold valid Florida licenses, of whom 9,260 were residing in the state in December. The abolition of the basic science examination and the citizenship requirement and the 1971 law authorizing license by endorsement have contributed to the dramatic increase in license applicants. The overall doctor-population ratio in Florida is now about 1 to 875. On the subject of administering and supervising the Physician's Assistant program authorized by the 1971 legislature, he emphasized that BME will not certify any physician's assistant unless he is a graduate of an approved program of at least two years' duration. None have been certified as of this date.

An interesting illustrated lecture on the Physician's Assistant program was given by Jack Fleming, M.D., of Pensacola, Chairman of the FMA Committee on Physician's Assistants and Medical Assistants. He traced the development of the program in Florida and presented an interesting discussion on the use of this new category of health personnel.

William H. Hubbard, M.D., of Daytona Beach, Chairman of the Committee on Continuing Education recommended that to maintain membership, FMA doctors be required to obtain at least 30 hours of continuing education per year. He also spoke of the need for enlarging the committee to include medical school representatives and others. He suggested that the FMA consider employing a full-time physician to supervise and coordinate all continuing medical education in Florida.

A report on the activities of the Peer Medical Utilization Review Committee was given by its chairman, James B. Byrne, M.D., of Miami. He announced that the federal government had modified its policy on withholding future Medicare payments to physicians slated for peer review. Under the new policy, should the total amount of fees in question be less than $4,000, there will be no suspension.

Floyd K. Hurt, M.D., FMA President and W. Harold Parham, Executive Vice President, reported on the current crisis in the professional liability insurance program. Unavoidable major problems have developed since September, including the carrier's insistence on taking a much closer look at each application its refusal to renew some policies at year's end, and its failure to use physicians as peer review.

One of FMA's busiest committees nowadays is the fledgling Ad Hoc Committee on Drug Abuse. The chairman, Robert P. Johnson, M.D., of Tallahassee, said the drug problem is so complex that the committee members are meeting now for two days every six weeks. Membership is composed of representatives from FMA, the Woman's Auxiliary to FMA, Florida Pharmaceutical Association, the State Department of Education, Board of Regents, Comprehensive Health Planning, the State Division of Health, Florida Bar, Juvenile Court judges, law enforcement, Florida Education Association, Florida Pediatric Society, the State Board of Medical Examiners and the clergy. Dr. Johnson described the various projects and recommendations of the committee and how it functions in an advisory capacity to the Committee on State Legislation and agencies of state government. He said that Miami is the largest port of entry for illicit drugs into the USA and that there are 15,000 hard core heroin addicts on the Gold Coast. These are reasons enough for us to become involved with the drug problem. "The profession has never failed in the past to come to the aid of the public during a period of crisis," he said, "and the drug crisis is upon us."

Thomas B. Thames, M.D., of Orlando, gave an interesting illustrated report on medical, hospital and first-aid services at Disney World. He is medical director of the sprawling amusement area near Orlando, and he and his partners provide coverage on a part time fee-for-service basis.

Raymond J. Fitzpatrick, M.D., of Gainesville, Chairman of the FMA Committee of 17, gave a history of the founding of Blue Shield and some reasons why we should support it (this is to be published in the April issue of JFMA).

Fred A. Butler, M.D., of Naples, Chairman of the hardest working FMA Committee, Relative Value Studies, gave a report on the 1971 FMA Relative Value Studies, saying that it should have been in the mail to all of you sometime in February.

Rep. Paul Rogers, of West Palm Beach, and Chairman of the Public Health and Environment Subcommittee, appearing as the principal speaker at the legislative seminar on Sunday morning, noted that the Nixon Administration wants HMO-type health care available to 90% of the nation's population by 1980, but "this will not happen," he declared. He said that the federal government has already provided approximately $6 million in planning grants to individuals for HMOs and will pay $30 to $50 million more in operational funds this year, all without authority of law. He stated that the HMO hearings probably will lead to a congressional study of the entire health care delivery system, but "we are going to get health decisions made by health people." His subcommittee will review 14 health programs next year, including the Regional Medical Programs and Comprehensive Health Planning. He stated, "Some of these programs have been perverted from the way they were originally intended." Heart and lung legislation will be introduced this year, as well as a bill to set up a drug office in the White House. Congress will take a look at peer review and there may be some encouragement toward widespread adoption of the problem-oriented medical record. Nonphysicians will have to be brought into the peer review process. In response to a question later, he said these nonphysicians might include hospital and nursing home officials and pharmacists, among others, but that M.D.s should constitute a majority. Since patients tend to overutilize the Medicaid program, some sort of "quick peer review right at the beginning rather than after services have been rendered might be the answer." While the AMA is becoming more responsive to its members in matters before Congress, he thinks the individual practicing physician should make his thoughts better known on Capitol Hill. AMPAC is becoming more influential because of its candidate support activities in addition to its political contributions. The Council of Medical Staffs appears to be working more through the Ways and Means Committee than through the Public Health Subcommittee. "I think it would be chaos for the country to jump into a program like Kennedy's overnight," Rep. Rogers said, "We should build and improve our present system."

Discussing other health matters, Rep. Rogers said he is concerned that the nation's chief health officer is but one of seven assistant secretaries of HEW and has limited access to the President. He plans to work for a cabinet-level Department of Health to be headed by an official of Secretary rank.

Without a doubt the best of the fourteen conferences, much credit should be given our officers, the full time staff, the many speakers and all those who contributed to putting it on.

Commentary

Is This Legislation Really Necessary?

Franklin J. Evans, M.D., LL.B.

Editor's Note: The following is a rebuttal to Dr. Sackett's bill, "Death with Dignity," which would provide three things: (1) A person in his right and rational mind could execute a document, much as a will or deed, to be registered with the appropriate local authority that would allow him under certain conditions which he could dictate (ie, doctors, the condition, etc.) under what circumstances he would be allowed to die; (2) In the absence of such a document, a parent, child or spouse would be permitted to request that the patient be allowed to die with dignity; (3) In the case of a staff or indigent patient with no known relatives, death would be allowed to occur under certain stipulations. It would require the written testimony of three staff doctors that life was without use or meaning, followed by judicial decree authorizing that death be allowed to occur—that heroic measures would not be taken to prolong the particular patient's life. It is in this latter category that Dr. Sackett sees the greatest need for such legislation.

A bill before the state legislature, "Death with Dignity," prefiled by Dr. Walter W. Sackett Jr., a Dade County member of the House of Rep-

resentatives and of the Florida Medical Association House of Delegates, has attracted widespread publicity and ballyhoo. It was the subject of a television documentary one year ago on Station WTVJ, Miami.

The reason for the bill's notoriety is not so much its worthiness but the emotional appeal of the melodramatic title. I am sure no one opposes the principle of dying "with dignity;" in fact, it is the only way anyone should die when that inevitable moment arrives. More important and pertinent is whether this type legislation is necessary, whether it provides something not now permitted, whether it accomplishes anything at all.

An analysis of the proposed legislation would force one to answer these inquiries in the negative. In the first place, the bill is vague, ambiguous and capable of varied interpretations. It would authorize a person of rational mind to execute a "document" to be registered with appropriate "local authority" that would allow him under "certain conditions," which he could dictate, under what "circumstances" he would be allowed to die. In the absence of such a document, a next of kin in a similar situation could request that the patient "be allowed to die with dignity." The quotes are mine and point up the areas which would be open to dispute and interpretation. What "local authority" could be cloaked with this responsibility? Who is to interpret the "circumstances?" In the final analysis, wouldn't it be a physician? The third part of the bill would provide that in the case of a staff or indigent patient with no known relatives a committee of three staff doctors would judge the meaningless or uselessness of the life and this would then be followed by a judicial decree authorizing death to be allowed to occur rather than resort to heroic measures to prolong life. Even if this were not such a cumbersome procedure, would it not be "passing the buck," ie, professional responsibility, from physicians where the responsibility belongs to a nonmedical person, a judge, whose training and background hardly qualifies him to make such a delicate decision?

In the second place, the bill would provide absolutely nothing that cannot be done now. The ultimate decision whether to continue to prolong life rests with the physician and the patient's family and cannot be decided by legislation. The bill, therefore, is useless, meaningless and superfluous. There is no legal or medical justification for it.

As an argument for his bill, Dr. Sackett is concerned over the fact that the training and indoctrination of young "medics" emphasize a primary dedication to preservation of life; therefore, he fears these doctors would be reluctant to allow life to end without first attempting heroic measures to prolong it. I cannot believe this to be true. Within the true context of the physician's responsibility there is room for moderation when it comes to preserving "meaningless" life. The physician's reluctance may stem from failure of proper communication between physician and family and a misunderstanding of the doctor's role in preserving life. With good rapport between doctors and patient or his next of kin and a conscientious desire to do the humane thing for a patient whose death is not only inevitable but actually merciful, everything proposed by Dr. Sackett can be done without legislation. The doctor's role in this delicate situation has been discussed and debated at length in the past few years. It has been the subject of innumerable articles in such eminent journals as the Journal of the American Medical Association, Southern Medical Journal, even in Life magazine (1/14/72). The late Pope Pius XII had something to say about it in "The Prolongation of Life" in 1957. In these pronouncements it has never been stated that a doctor, with complete and voluntary consent and approval of the next of kin, could not permit a patient, totally and irretrievably removed from "meaningful" life, to die a natural death or, as Dr. Sackett would state, to die with dignity.

The sponsor of the "Death with Dignity" bill derives great comfort from the thousands of letters he has received from people, mostly old folks, supporting his bill. If the letters he has been receiving are anything like the ones I have read in the local newspaper it is apparent that these poor misguided people are totally lacking in an understanding of the fundamental principle and purpose involved in the proposed legislation.

As an example, a poignant and overdramatized story appeared in the November 18, 1970 issue of the Miami Herald concerning a devoted elderly couple whose lives were suddenly shattered by the devastating news that one of them had a malignancy with metastases. There followed a desperate, costly struggle to contain the ravages of the disease and, finally, the heartbreaking realization of the futility of the struggle. At this point, Mr. D. injected Dr. Sackett's bill "that would enable people to make this decision as to when life shall not be prolonged beyond the point of a meaningful existence." How would it do that? There is

nothing in the bill which would help him make this decision. In the last sentence of the article, Mr. D. answered his own dilemma when he said, in response to a question whether he would permit another operation on his wife and a chance for a few more weeks of reprieve, "I wouldn't allow it. It would serve no purpose." Thus, without realizing it, he made the final, agonizing decision regarding his wife's future without the help of or need for legislation. Each letter I have read is charged with an emotional and sentimental slant obviously colored by some single personal experience.

I suspect that as the bill and its title have gained notoriety, the sponsor has been carried away by its oversentimental appeal because he has been treading a thin line between natural death and euthanasia, even though he vehemently denies this. In several articles on the subject, he has made a strong plea for his bill by injecting into the picture congenitally defective children who are hopelessly retarded. While it is true that these hapless children may never go beyond the "diaper" stage, it is equally true that they tend to survive with minimal medical care. In their own pitiful world, all they need to survive is to be fed and clothed (other than definitive training.) How do they fit into the provisions of the proposed bill? Not at all, unless the bill authorizes mercy killing which the author disclaims.

In a recent newspaper interview, Dr. Sackett asked several questions of himself, like "just how far are we going with treatment?" "are we just going to prolong life, such as it is?" I wonder whether he really believes his bill will or can answer these questions. He insists upon the need for his bill so that any person shall have the right to "die with dignity" and not have his life prolonged beyond the point of "meaningful existence." Lofty, high-sounding words, but how and by whom are they to be interpreted? What is meant by "beyond the point of meaningful existence?"

Dr. Franklin H. Epstein, a professor of medicine at the Yale University Medical School, challenging the view that the patient should be allowed to die when hope of recovery is gone, has said, "I find it very difficult to agree that there is ever a situation where the doctor should permit the patient to die through judicious neglect." A person who is psychotic and completely out of touch with reality may be living a "meaningless" existence. Yet does he fall within the permissiveness of the proposed statute?

Finally, there is still another reason, not as apparent but even more portentous, for resisting this bill. It is recognized that all legislation by its very nature is restrictive as well as permissive. Thus, one must follow the requirements of a statute strictly or be in violation of it. If Dr. Sackett's proposal became law, it would bind every physician and severely limit that which he can do now simply and quietly by mere consultation with the patient's family. As a physician, I fear that a proposal like the "death with dignity" statute would become a burden rather than an aid to physicians in this difficult situation because the question could become entangled in a legal morass. As an attorney, I can foresee a sprouting of lawsuits based upon some specious allegations of failure to follow the letter of the law in allowing people to "die with dignity." I would anticipate an increase in malpractice suits based upon the premise that the law was not strictly adhered to in allowing a "meaningless life" to end. If this prediction were to come true, I am sure it would weigh heavily on the conscience of the bill's sponsor.

As George Washington lay dying he implored his doctors: "I pray you to take no more trouble about me. Let me go off quietly." The doctors acquiesced. After heroic measures were stopped, the President used his remaining time to dictate to his secretary his wishes on burial and other matters. The Father of our Country assumed calm control of his final hours over 100 years ago without legislation, would he be permitted to do likewise today or would special legislation be necessary?

I believe it would serve the people and their physicians best to desist from pushing legislation which has no useful or helpful purpose and which would accomplish nothing more than can be done without it.

▶ Dr. Evans, 147 Alhambra Circle, Coral Gables 33134.

Subcommittee on the Management of Youthful Drug Offenders (Ad Hoc Committee on Drug Abuse)

Mrs. Arnold J. Spanjers, *Chairman*

Recognition of the need for treatment and rehabilitation centers for youthful drug offenders adjudicated by the courts, led to the establishment of the Subcommittee on the Management of Youthful Drug Offenders within the FMA's Ad Hoc Committee on Drug Abuse. It was believed that county jails and detention homes offered no solution but instead increased the criminalization of youth.

Requests for information regarding their youthful drug offender programs were sent to the other 49 Governors of the states. To date, 46 states have responded and only six have youthful drug programs, per se. A report of our survey will be sent to the other states for we feel that this committee is solely in possession of such information.

We recently polled 78 Juvenile Court judges of Florida asking three questions: (1) What resources exist in your community for incarceration or treatment of youthful drug offenders? (2) Are you satisfied with the handling and facilities available to you? (3) What would be your approach or what would you like to see done? Over 60% replied and almost to a man, the answer to the first question was "county jails or detention homes." Replies to the second question were "not satisfied with facilities;" "none exist here," or "the local community is struggling to solve this problem." The third question brought forth strong feelings that "not enough was being done in Florida regarding the drug problem;" that "little or no statewide facilities existed," and "that something should be legislated and funded by the Florida legislature." Several judges commended the Florida Medical Association for attempting to solve this modern day dilemma.

The subcommittee chairman is working with the Division of Youth Services, seeing what they have to offer and also trying to help establish drug abuse programs for students and counselors in the state training schools. On-site visits have been made to these schools and trips to open therapeutic communities such as the Criswell and Halfway Houses are in the offing. A report will be presented to the full Drug Abuse Committee and a position taken.

We have been requested to prepare a detailed, objective report for Senator Mallory Horne of Tallahassee. This must be ready in the Fall so that Senator Horne, president of the Florida Senate, will have a clearer picture of what has and is being done and what needs doing regarding the drug problem in Florida. The committee is pleased to comply and a clear, unbiased report will be prepared.

This is a multidisciplined, dedicated group, much concerned with the treatment and rehabilitation of children with drug problems. If time and energy spent are a barometer to success, pressures from this subcommittee will explode, and our missions shall not be *impossible,* but *accomplished.*

Mrs. Spanjers, 1700 - 15th Street, N.W., Winter Haven 33880.

Judicial Council Opinion

The FMA Judicial Council has received numerous inquiries about lay-operated services which offer physicians after-hours practice coverage, including house calls. This matter was referred to the FMA Judicial Council which rendered the following opinion:

"In the opinion of the Judicial Council, there is a place in the health care delivery system for organized services which provide physicians with coverage of their medical practices at night, on weekends and during vacation periods; however, the Council's approval of these services assumes that all physicians participating in any way will at all times abide by the Principles of Medical Ethics. It is ethical for a physician to pay a fee to a layman if it is the layman's only function to *assure* that there is an adequate number of physicians on call or available to provide adequate practice coverage. The layman who supervises such a service must not pay a salary to any physician providing after-hours coverage, nor shall such a layman collect or share in a fee paid by a patient for medical service. Physicians agreeing to provide coverage through this type of service must be licensed by the Florida State Board of Medical Examiners. The fee paid for after-hours medical service is a matter of concern only to the physician who rendered the service and the patient."



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Medical News

FMA Officer on National Commission

The American Medical Association and the American Nurses' Association have established a National Joint Practice Commission which will discuss and recommend changes in medical and nursing practice.

James W. Walker, M.D., of Jacksonville, Secretary-Treasurer of the Florida Medical Association and a member of the AMA Committee on Nursing, has been named to the 16-member Commission.

Areas to be examined by the AMA-ANA group will include current clinical practice, patient care procedures, new methods of providing care, and relationships with new categories of health care personnel.

AMA Conference at Fort Lauderdale

About 600 physicians and others are expected to attend the Sixth National Congress on the Socio-Economics of Health Care at Fort Lauderdale, April 6-8.

"Health Services in the '70s" is the theme for the meeting, sponsored by the Council on Medical Service of the American Medical Association. Speakers will include Merlin K. DuVal Jr., M.D., Assistant Secretary of the Department of HEW for Health and Scientific Affairs.

Information may be obtained from: Division of Medical Practice, American Medical Association 535 North Dearborn Street, Chicago 60610.

Dr. Coleman on Federal Committee

President Nixon has appointed Francis C. Coleman, M.D., of Tampa, to the Committee on the Health Services Industry. He succeeds William E. Lotterhos, M.D., of Jackson, Miss., who resigned.

Long active in the affairs of organized medicine, Dr. Coleman is an alternate delegate to the American Medical Association and Vice Chairman of the AMA Council on Health Manpower. He also has served as President of the College of American Pathologists and as Chairman of the AMA Council on Legislation.

Dr. Benton Named to Emory Alumni Board

Dr. Curtis D. Benton Jr., a Fort Lauderdale ophthalmologist and a graduate of Emory's medical school, has been named as a new member of Emory University's Board of Trustees. He has been active in support of Emory's Candler School of Theology, establishing a scholarship endowment fund in 1955. Dr. Benton is a diplomate of the American Board of Ophthalmology and the American Board of Otolaryngology. He is also a fellow of the American College of Surgeons. A well known speaker, nationally and internationally, he is also a member of the consulting editorial staff of the Journal of the Florida Medical Association.

Emergency Care Course in Florida

The American College of Surgeons will sponsor a series of three and four-day courses on "Treatment of the Seriously Injured or Ill in the Emergency Department."

One of the 13 courses will be conducted in Jacksonville, May 15-20. The instruction is intended for physicians who work full-time or on call in hospital emergency departments, and for emergency room nurses.

Registration fees will vary from $50 to $75. Additional information may be obtained by contacting Dr. Oscar P. Hampton, Jr., Director of Trauma Division, American College of Surgeons, 55 East Erie Street, Chicago, Ill. 60611.

Miami Medical School Gets Grant

The Andrew W. Mellon Foundation has presented the University of Miami School of Medicine with a grant of $250,000 for completion of the top three floors of the eight-story Rosenstiel Medical Sciences Building.

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INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.
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WARNINGS: *Use in children:* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.
PRECAUTIONS: Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.
ADVERSE REACTIONS: Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis and thrombocytopenia; drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS-depressant and (less often) stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress.
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Indications: Acute, recurrent or chronic urinary tract infections (primarily cystitis, pyelitis, pyelonephritis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies.

IMPORTANT NOTE: *In vitro* sulfonamide sensitivity tests are not always reliable. The test must be carefully coordinated with bacteriologic and clinical response. When the patient is already taking sulfonamides, follow-up cultures should have aminobenzoic acid added to the culture media.

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Precautions: Use with caution when impaired renal or hepatic function, severe allergy or bronchial asthma is present. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis (frequently a dose-related reaction) may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia, methemoglobinemia. *Allergic reactions:* Erythema multiforme (Stevens-Johnson syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia, allergic myocarditis. *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis, stomatitis. *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L.E. phenomenon have occurred with sulfonamide therapy. Sulfonamides bear certain chemical similarities to some goitrogens, diuretics and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents.

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*Koch-Weser, J., *et al.: Arch. Intern. Med., 128*:399, 1971.

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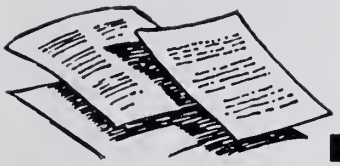
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Letters

Dear Editor:

In October of 1971 a new procedure was introduced in regard to obtaining initial medical evidence from treating physicians on patients applying for Disability Benefits under Social Security . . .

Heretofore, the district offices of the Social Security Administration interviewed and took claims of applicants alleging disability and assisted in requesting initial medical information from physicians who had seen the patient and from institutions having some information about the patient. After this was gathered, it was then sent to the Disability Determination Section in the state agency so that we could make a determination as to whether or not the individual met the legal requirements for disability under Social Security regulations.

As the physicians in Florida know, this old procedure resulted in many physicians being asked about a patient who had no knowledge about the patient's alleged disability. In addition, the physician had no idea what information was needed from him in view of the fact that only a Social Security form requesting medical information of a general nature was sent.

The new procedure shifts the responsibility for assisting the patient in obtaining medical information from the Social Security office to the Disability Determination Section in the State Division of Vocational Rehabilitation, State Department of Health and Rehabilitative Services. In the State Disability Determination Section we have the services of seven full-time and ten part-time physicians to review the allegations of the patient and the available medical information. Therefore, with this medical expertise we hope to be able to request medical information only from those physicians who would be likely to have information relative to the patient's alleged disability. In addition, we will ask the physician for the specific information needed to make a legal determination rather than simply sending him a routine form and asking for all the medical information he has. By this new procedure fewer physicians will be contacted for medical information. In addition, the medical information requested will be of a specific nature so that the physician can respond to these specific questions and know what information is needed. *There is no change in the claimant's responsibility under this new procedure.* It has always been, and still is, the responsibility of the patient to furnish medical as well as other evidence to support his claim of disability. It is only the responsibility of the state agency to aid him in obtaining this information. *Therefore, the payment of any charge the physician makes for preparing this information on behalf of his patient is the responsibility of the patient.*

We have available a handbook for physicians giving information on the Social Security Disability Program, outlining the extent an individual's medical impairment must be in order for the individual to meet legal requirements for disability under Social Security. We will mail one to any physician on request. Address your request to me. Room 229, 725 South Bronough Street, Tallahassee, Florida 32304.

A. E. Ogden, M.D.
Chief Medical Consultant
Florida Division of
Vocational Rehabilitation

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MEETING

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cautions: Ideally, supportive therapy is icated for anemic, dehydrated, or mal-nourished patients prior to initiation of anthelmintic therapy. In presence of hepatic or renal dysfunction, patients should be carefully monitored.
Adverse Reactions: Most frequently encountered are anorexia, nausea, vomiting, and dizziness. Less frequently, diarrhea, epigastric distress, pruritus, weariness, drowsiness, giddiness, and headache have occurred. Rarely, tinnitus, hyperirritability, numbness, abnormal sensation in eyes, blurring of vision, xanthopsia; hypotension, collapse; enuresis; transient rise in cephalin flocculation and SGOT; perianal rash, cholestasis and parenchymal liver damage; hyperglycemia; transient leukopenia; malodor of the urine, crystalluria, hematuria; appearance of live Ascaris in the mouth and nose. Hypersensitivity reactions include: fever, facial flush, chills, conjunctival injection, angioedema, anaphylaxis, skin rashes, erythema multiforme (including Stevens-Johnson syndrome), and lymphadenopathy.
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Dosage: Adults: One or two tablets three or four times daily. Dosage can be adjusted depending on diagnosis and severity of symptoms. Children 2 to 12 years: One half or one tablet three or four times daily. Tablets may be chewed or swallowed with liquids.



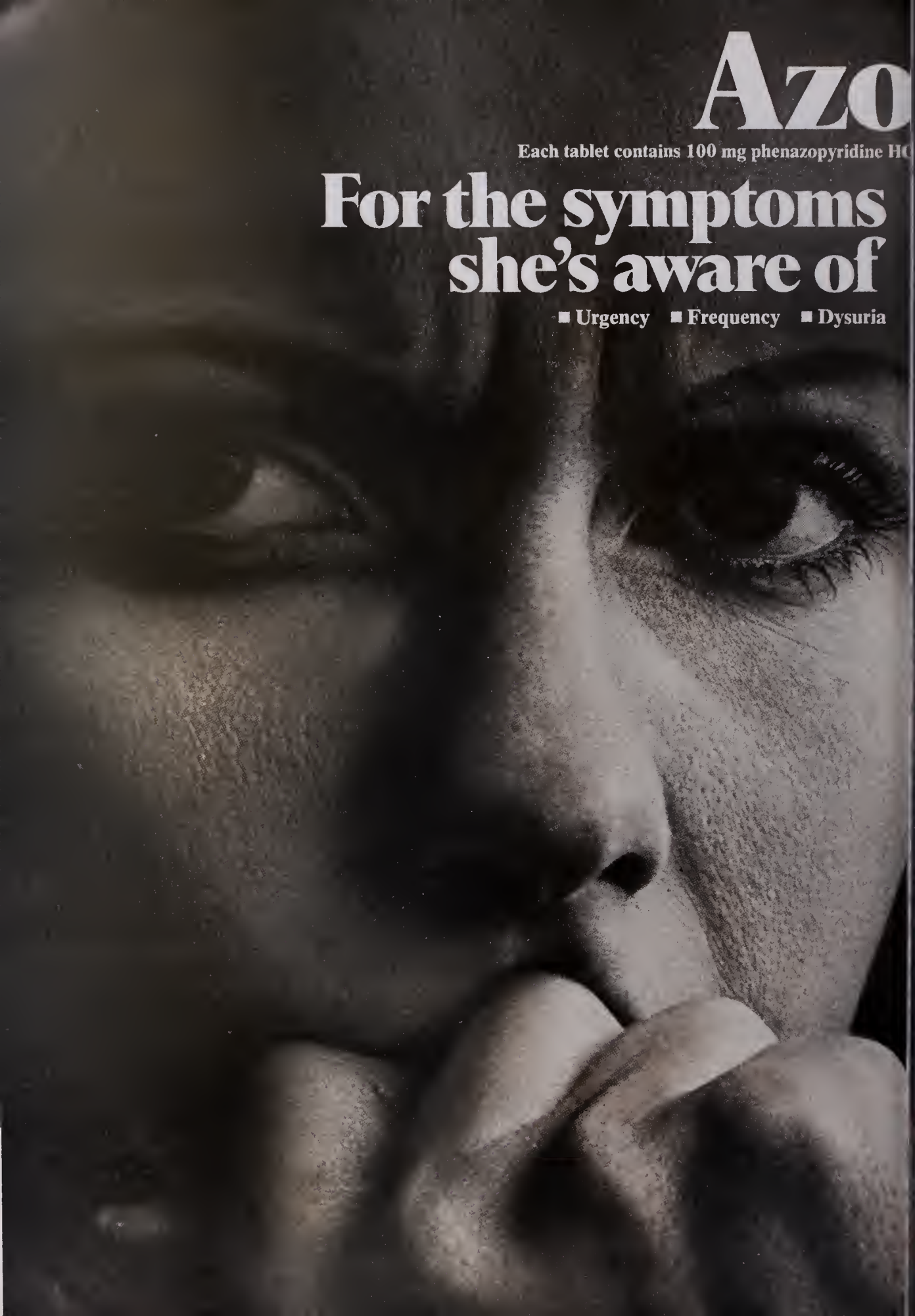
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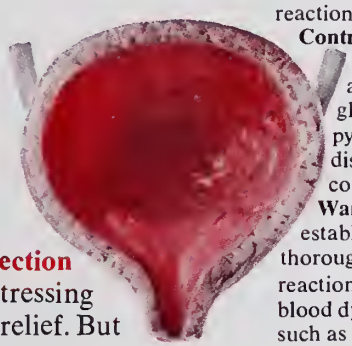
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In from 2 to 3 hours after the initial 2-Gm adult dose of o Gantanol, therapeutic blood and urine levels begin to control sceptible *E. coli* as well as susceptible gram-negative and m-positive pathogens. Subsequent b.i.d. doses maintain anti-terial levels throughout a 24-hour period—especially important help control bacterial build-up in urine retained during sleeping urs. The usual precautions in sulfonamide therapy, including intenance of adequate fluid intake, should be observed. The st common side effects are nausea, vomiting and diarrhea.

'll feel better while she gets better

As the antibacterial action of Gantanol begins to control the ection, the analgesic action of the Azo component starts relieving symptoms associated with her infected, inflamed and irritated dder. In acute, nonobstructed cystitis—when rapid relief of mptoms and early control of infection are essential—prescribe o Gantanol, the basic therapy that helps your patient feel ter while she gets better.

acute painful nonobstructed cystitis

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. *Important Note:* Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response. Add aminobenzoic acid to culture media for patients already taking sulfonamides. Increasing frequency of resistant organisms currently is a limitation of the usefulness of antibacterial agents. Blood levels should be measured in patients receiving sulfonamides for serious infections, since there may be wide variations with identical doses; 12 to 15 mg/100 ml is considered optimal for serious infections; 20 mg/100 ml should be the maximum total sulfonamide level, as adverse reactions occur more frequently above this level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period. Contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with gastrointestinal disturbances, because of phenazopyridine HCl component.

Warnings: Safe use in pregnancy has not been established, and teratogenicity potential has not been thoroughly investigated. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported; clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts and urinalysis with careful microscopic examination should be performed frequently during sulfonamide therapy.

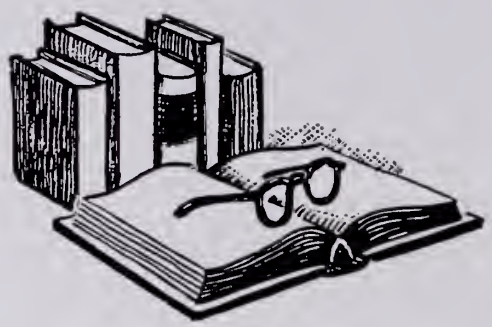
Precautions: Use with caution in patients with impaired renal or hepatic function, severe allergy, bronchial asthma and in glucose-6-phosphate dehydrogenase-deficient individuals. In the latter, hemolysis, a frequently dose-related reaction, may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia; *allergic reactions:* erythema multiforme (Stevens-Johnson syndrome), skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis; *gastrointestinal reactions:* nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis; *C.N.S. reactions:* headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia; and *miscellaneous reactions:* drug fever, chills, toxic nephrosis with oliguria and anuria, polyarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide and thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Usual adult dosage for acute, painful phase of urinary tract infection is 4 tablets initially, then 2 tablets morning and evening. If pain persists beyond seven days, causes other than infection should be sought. After relief has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine soon after ingestion.

How Supplied: Tablets, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl, bottles of 100 and 500.



Book Review

Neurosis is a Painful Style of Living by Samuel I. Greenberg, M.D., Signet Books, The New American Library, Incorporated, New York, 1971.

Our colleague, Sam Greenberg, has drawn on his long experience to carefully put together a sound, well-written, and very readable new book. The theme of the book as expressed in its title is carried through the entire book, reflecting Dr. Greenberg's concerned, empathetic, and quiet good taste in writing a work directed primarily at the layman. Though written for lay people, particularly spouses, patients, and parents of child patients, the solid, well thought-out and clearly-written chapters of this book are eminently readable for beginning workers in our field.

Dr. Greenberg separates his work into three parts. The first of these deals primarily with the internal processes of neurosis, its aims and patterns of handling anxiety. In the second part of his book, Dr. Greenberg goes on to describe how these faulty internal patterns are expressed in interpersonal relations covering the full gamut of a person's life space. Finally, in the third part, Dr. Greenberg points out how people can move towards a healthier style of living by self-discovery and self-help; and in addition, very lucidly describes the various forms of professional help that are available to those with emotional difficulties. In general throughout this book, Dr. Greenberg follows Karen Horney's model of personality development and structure; a model with which he is intimately conversant.

The reviewer feels that we all owe Dr. Greenberg a resounding vote of thanks for producing a concise, clearly-written and quite readable work for lay people which does not appeal to the more sensationalistic and neurotic interests of its readers. Certainly, in this day of the mass media's exploitation of the public's neurotic traits and wishes for magical solutions, a book such as Dr. Greenberg's is a breath of fresh air.

Carl H. Marlowe, M.D.
Coral Gables

Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

Lasers in Medicine by Leon Goldman, M.D. and R. James Rockwell Jr. Pp. 385. Illustrated. New York, Gordon and Breach, Science Publishers, Inc., 1971.

Current Concepts in Dyslexia edited by Jack Hartstein, B.S., M.D. Pp. 212. 34 Illustrations. Price $12. St. Louis, The C. V. Mosby Company, 1971.

Pathology, Sixth Edition, Volume One & Two, edited by W. A. D. Anderson, M.D. Pp. 1,901. 1,572 Illustrations. Price $29.50. St. Louis, The C. V. Mosby Company, 1971.

Pediatric Therapy, Fourth Edition, edited by Harry C. Shirkey, M.D. Pp. 1,221. 443 Illustrations. Price $34.50. St. Louis, The C. V. Mosby Company, 1972.

Approach to the Medical Care of the Sick Newborn by Sophie H. Pierog, M.D. and Angelo Ferrara, M.D. Pp. 292. 42 Illustrations. Price $11.50. St. Louis, The C. V. Mosby Company, 1971.

Neurosis is a Painful Style of Living by Samuel I. Greenberg, M.D. Pp. 142. Price $.95. New York, Signet Books, 1971.

Biochemical Profiling in Diagnostic Medicine by Joseph A. Preston, M.D. and David B. Troxel, M.D. Pp. 51. Price $2.50 for set of five. Tarrytown, New York, Technicon Instruments Corporation, 1971.

CRC Manual of Nuclear Medicine Procedures by William H. Beierwaltes, M.D., John W. Keyes Jr., M.D. and James E. Carey, M.S. Pp. 137. Price $19.90. Cleveland, Ohio, CRC Press, 1971.

Symposium on the Functional Physiopathology of the Fetus and Neonate, Clinical Correlations. Edited by Harold Abramson, M.D. Pp. 182. 61 illustrations. Price $15.00. St. Louis, The C. V. Mosby Company, 1971.

Handbook of Clinical Dermatoglyphs by Musallam S. Elbualy and Joan D. Schindeler. Pp. 64. Price $6.95. Coral Gables, University of Miami Press, 1971.

Synopsis of Pediatrics by James G. Hughes, M.D. Pp. 1141. Illustrated. Price $14.50. St. Louis, The C. V. Mosby Company, 1971.

Review of Physiological Chemistry by Harold A. Harper, Ph.D. Pp. 529. Illustrated. Price $8.00. Los Altos, California, Lange Medical Publications, 1971.

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PRECAUTION: Do not use when symptoms of appendicitis are present and discontinue use if skin rash appears. Dependence on laxatives can result from continued use.

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MEETINGS

Approved by FMA Committee on Continuing Education

MARCH

15-18 Fourth Teaching Conference in Clinical Cardiology, Sheraton-Four Ambassadors Hotel, Miami. For information: Michael S. Gordon, M.D., Box 875, Biscayne Annex, Miami 33152.

15-19 Fourth Annual Nuclear Medicine Seminar, Playboy Plaza Hotel, Miami Beach. For information: Susan R. Cohen, B.A., Div. of Nuclear Medicine, Box 875, Biscayne Annex, Miami 33152.

21-25 Selected Topics in Gastrointestinal Roentgenology, Fontainebleau Hotel, Miami Beach. For information: Manuel Viamonte Jr., M.D., Box 875, Biscayne Annex, Miami 33152.

24-25 Postgraduate Surgical Symposium, Cedars of Lebanon Hospital, Miami. For information: Eugene L. Komrad, M.D., Cedars of Lebanon Hospital, 1321 N.W. 14th St., Miami 33125.

26-29 Selected Topics of Cancer Management, Americana Hotel, Miami Beach. For information: Komanduri Charyulu, M.D., Box 875, Biscayne Annex, Miami 33152.

Florida State Board of Medical Examiners:
July 23-25, 1972, Miami Beach

For information: Mrs. Marjoriann Keebler, Administrative Assistant, Florida State Board of Medical Examiners, 2717 E. Oakland Pk. Blvd., Fort Lauderdale, Fla. 33306.

National and Regional Meetings Held in Florida

APRIL

3- 8 American College of Radiology, Fontainebleau Hotel, Miami Beach. Ex. Dir.: William C. Stronach, J. D., 20 N. Wacker Dr., Chicago 60606.

23-24 American Otological Society, Breakers Hotel, Palm Beach. Sec.: Wesley H. Bradley, M.D., 1111 E. Genessee St., Syracuse, N.Y. 13210.

23-25 American Academy of Facial Plastic and Reconstructive Surgery, Breakers Hotel, Palm Beach. Sec.: Carl N. Patterson, M.D., 1110 W. Main St., Durham, North Carolina 27701.

24-25 American Broncho-Esophagological Association, Breakers Hotel, Palm Beach. Walter H. Maloney, M.D., 2065 Adelbert Rd., Cleveland 44106.

24-28 Association for Research in Vision and Ophthalmology, Sheraton Sandcastle, Sarasota. Sec.: Herbert E. Kaufman, M.D., Dept. of Ophthalmology, University of Florida College of Medicine, Gainesville 32601.

26-27 American Society for Head and Neck Surgery, Breakers Hotel, Palm Beach, Sec.: William M. Trible, M.D., 1234-19th St., N.W., Washington, D.C. 20036.

25-27 American Laryngological, Rhinological and Otological Society, Breakers Hotel, Palm Beach. Ex. Secy.: Louis E. Silcox, M.D., 108-111 Lankenau Medical Bldg., Philadelphia, Pa. 19151.

28-29 American Laryngological Association, Breakers Hotel, Palm Beach. Sec.: Frank D. Lathrop, M.D., R.D. #1, Pittsford, Vt. 05763.

MAY

8-11 Aerospace Medical Association, Americana Hotel, Miami Beach, Ex. V.P., Merrill H. Goodwin, M.D., Washington National Airport, Washington, D. C. 20001.

14-19 American Radium Society, Boca Raton, Florida. Sec.: Jerome M. Vaeth, M.D., 1600 Divisadero St., San Francisco 94115.

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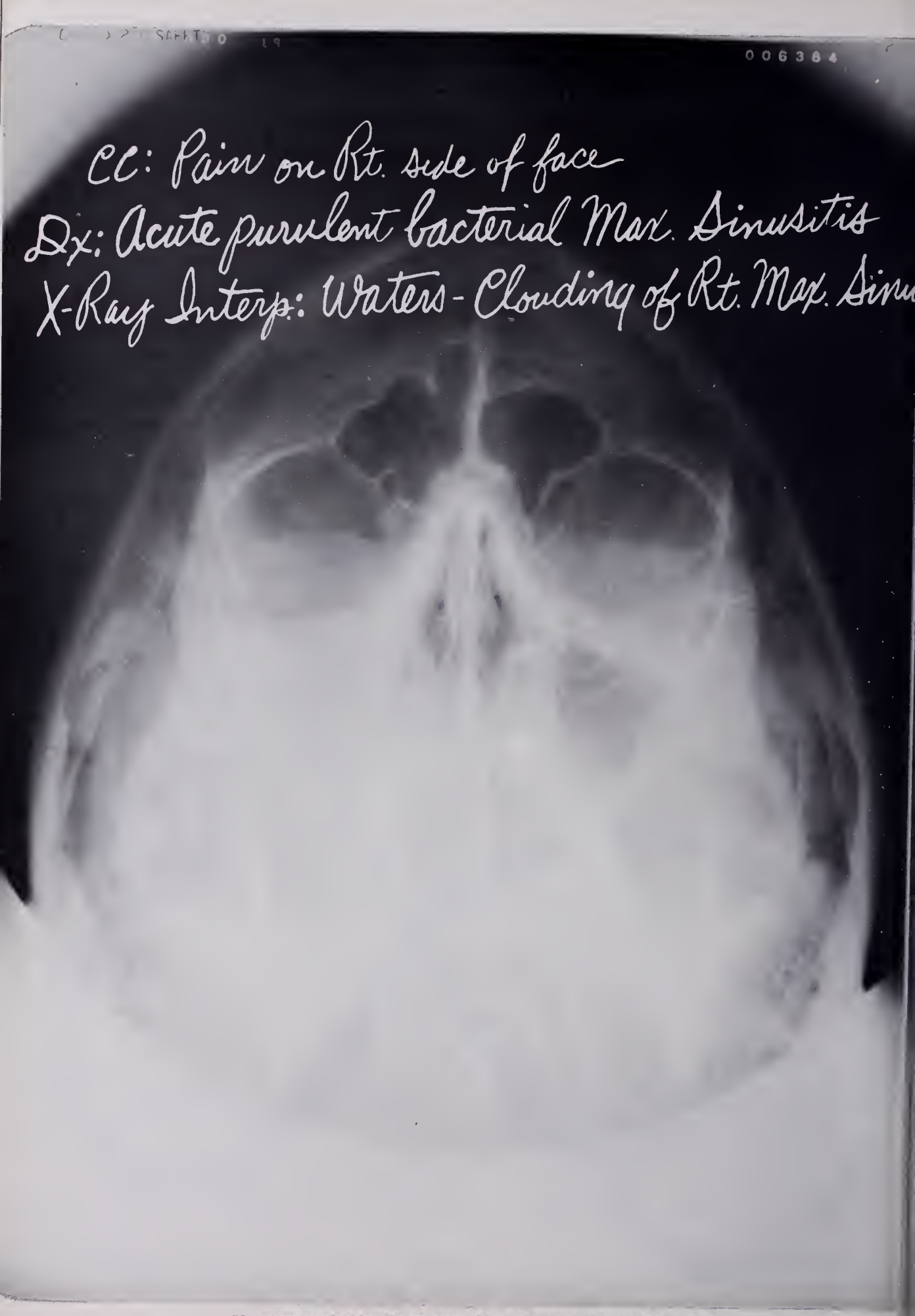
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Fort Lauderdale, Florida 33308

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Licenses to Practice Medicine in Florida Granted By Reciprocity or by Endorsement of Credentials

The Florida State Board of Medical Examiners report that 134 applicants have been issued licenses to practice medicine in Florida by reciprocity or by endorsement of credentials on November 20, 1971 in Naples, Florida. The names, towns, medical school and year of graduation follow:

Aber, John M., Greensburg, Pa. (Hahnemann 1967)
Adler, George T., Satellite Beach (Columbia 1966)
Agarwal, Ramesh C., Philadelphia (Agra U. 1961)
Andrake, William, Chevy Chase, Md. (Pittsburgh U. 1968)
Artzner, Leon F., Columbus, Ohio (Ohio U. 1969)
Appelrouth, Daniel J., Miami (Miami U. 1970)

Babat, Chester C., Columbus, Ohio (NY Downstate 1966)
Baggish, Michael S., Pikesville, Md. (Louisville U. 1961)
Bamford, Joel T. M., Hollywood (Johns Hopkins 1966)
Bayless, Steven, Tampa (Temple 1965)
Bayonet-Rivera, Natalio P., Isla Verde, Puerto Rico (Tufts 1963)
Beadling, Leslie W., Clinton, Md. (Temple 1964)
Betancourt, Oscar, Miami (Illinois U. 1970)
Bhupathy, Kalavathi, Fairmont, W. Va. (Bangalore M. C. 1961)
Bhupathy, Vellore R., Fairmont, W. Va. (Bangalore M. C. 1961)
Blacker, Barry F., Midwest City, Okla. (NY Downstate 1967)
Bob, Bruce A., Coral Gables (N.Y. Med. Coll. 1970)
Byrnes, John J., Miami (Tufts 1968)

Campbell, Doyle R., Miami (Miami U. 1970)
Cardwell, Ruth A., Decatur, Ga. (Ohio U. 1969)
Cerevka, Joseph, Brooklyn (U. Czech. 1962)
Clark, James A. Jr., St. Petersburg (Alabama U. 1970)
Coccaro, Alfred P., Miami (NY Syracuse 1967)
Cohn, Martin A., Miami (Miami U. 1970)
Colon, Angel R., Miami (Georgetown U. 1966)
Cook, Robinson II, Hartford, Conn. (Temple 1967)
Cook, Terrence J., Gainesville (Loyola Stritch 1966)
Cooper, Joel D., Boston, Mass. (Harvard 1964)
Cuva, Anthony, Macomb, Ill. (Loyola Stritch 1962)

Davis, Charles A., Tampa (Harvard 1970)
Davison, John F., Coral Gables (N.Y.U. 1964)
Demas, Theodore, Lake City (Nat'l U. of Athens 1957)
Deol, Jasbir S., Newport News, Va. (Punjab U.-India 1960)
Dubiel, Gail C., Miami (Boston U. 1967)
Duchin, Harvey E., Penn Valley, Pa. (N. J. Med. Coll. 1964)

Engel, Toby R., Columbus, Ohio (N.Y.U. 1966)
Eye, Earl H. Jr., Jacksonville (W. Va. U. 1970)

Fagin, Ronald R., Fort Ord, Calif. (Duke 1965)
Farrell, Kenneth H., Rochester, Minn. (Illinois U. 1967)
Feinstein, Richard J., Coral Gables (N.Y. Syracuse 1968)
Feldman, Ronald E., Miami (Rochester U., 1969)
Feldman, Sheldon H., New York (N.Y.U. 1965)
France, Joseph M. Jr., Baltimore (Maryland U. 1966)

Garriga, Francisco J., Miami (Washington U. 1970)
Gelfand, Francine L., Bergenfield, N.J. (N.J. Med Coll. 1965)
Gelfand, Philip N., Bergenfield, N.J. (Albert Einstein 1963)
Gerber, Saul B., Homestead AFB (Maryland U. 1966)
Gladnick, Marshall I., Hollywood (N.Y. Med. Coll. 1965)
Goodman, Stephen J., Tampa (N.Y.U. 1967)
Gordon, Joel P., Stamford, Conn. (Tufts 1967)
Graham, Gary C., Pensacola (Illinois U. 1966)
Grantham, Don E., Newport News, Va. (Florida U. 1970)
Graybiel, Ashton L., Pensacola (Bowman Gray M.S. 1966)
Gross, Mark, Fort Stewart, Ga. (N. Y. Downstate 1965)
Gruner, George, Chicago (Northwestern 1964)
Gunsberg, Melvin J., Fort Belvoir, Va. (N. Y. U. 1963)

Halley, Henry, Pensacola (Kentucky U. 1970)
Hanna, Hanna H., New York (Ain Shams U. 1955)
Hennekens, Charles H. Jr., Hollywood (Cornell 1967)
Hirsch, Henry D., North Miami Beach (Miami U. 1970)
Hochberg, Martin N., Wychoff, N. J. (N. Y. Med. Coll. 1963)
Huberman, Jean P., Colorado Springs (Dalhousie U. 1967)
Hussey, Francis D. Jr., Scott AFB, Ill. (N. J. Med. Coll. 1966)

Jackman, William M., Orange Park (Oklahoma U. 1967)
Janis, Mark G., Sarasota (N. Carolina U. 1970)
Johnson, John W., Topeka, Kansas (Louvian U. 1967)

Kaine, Richard F., Rochester, Minn. (N. Y. Buffalo 1968)
Kaiser, Harvey O., Tampa (Illinois U. 1965)
Kaplan, Barry S., Miami (Hahnemann 1963)
Kaul, Stephen L., Tampa (N. J. Med. Coll. 1969)
Klein, Elmer F. Jr., Gainesville (Missouri U. 1965)
Kronman, Barry S., Passaic, N. J. (N. Y. U. 1965)

Layden, William E., Louisville, Ky. (Vermont U. 1963)
Lee, David P., Jacksonville (W. Va. U. 1970)
Lenney, Walter S., Columbus, Ohio (Ohio U. 1969)
Levin, Harvey A., Baltimore (Jefferson M. C. 1964)
Levitan, Alexander A., Minneapolis (Rochester U. 1963)
Lewit, Robert T., Washington, D. C. (Harvard 1963)
Lipson, Jeffrey, New York (N. Y. U. 1968)
Litvak, Baris I., Miami (N. Y. Buffalo 1970)
Longo, Michael R. Jr., Tucker, Ga. (N. Y. M. C. 1963)

Malanga, Michael R., Orange Park (N. Y. Downstate 1970)
Manspeizer, Sheldon, Hartsdale, N. Y. (N. Y. Downstate 1962)
Marshall, Myron H., Williamsville, N. Y. (N. Y. Buffalo 1965)
Martin, Benjamin G. Jr., Tampa (So. Calif. U. 1964)
McCaleb, William E. II, Winter Park (Texas U. 1966)
McElroy, Michael B., Miami (Missouri U. 1969)
McElroy, Carla N., Miami (Missouri U. 1970)
Meek, Neva M., Orlando (Loma Linda 1970)
Michael, Manouchehr, Yonkers, N. Y. (Tehran U. 1966)
Miscia, Vincent F., Gainesville (N. J. Med. Coll. 1964)
Moake, Joe L., Key Biscayne (Johns Hopkins 1967)
Morris, Lawrence, Pensacola (W. Va. U. 1969)

Newman, Bernard R., Key West (N. Y. M. C. 1967)
Nielsen, Louis T., Orange Park (Washington U. 1964)

Olans, Richard N., Jacksonville (Tufts 1970)
Oliver, Robert P., Victorville, Calif. (Miami U. 1968)
Onstad, Gordon D., Irving, Texas (Florida U. 1966)

Pacin, Michael P., Miami (Washington U. 1969)
Pinzon, Jairo, Hinsdale, Ill. (Colombia Nat'l U. 1959)
Pollard, Richard B. Jr., Casselberry (Maryland U. 1970)

Reingold, Marvin, Howard Beach, N. Y. (Toronto U. 1955)
Richmond, Allen C., Jacksonville (Jefferson M. C. 1970)
Riggall, Frank C., Miami (W. Va. U. 1970)
Rizzuto, Vincent J., Forest Hills, N. Y. (Georgetown 1962)
Rosenberg, Eugene B., Miami (Harvard 1965)
Rosenthal, Samuel G., Orange Park (N. Y. Syracuse 1964)
Rutberg, Michael, Philadelphia (Pennsylvania U., 1966)

Saddoris, Thomas J. II, Key Biscayne (Temple 1969)
Saltzman, Robert I., Orlando (N. Y. M. C. 1970)

Saltz, Judith, Bronx, N. Y. (Pennsylvania M. C. 1969)
Sansone, Peter F., Coral Gables (Maryland U. 1967)
Saperstein, Morris L., Limestone, Maine (Tufts 1967)
Schechter, Gary L., Galveston, Texas (N. Y. Upstate 1963)
Schiffer, Charles F., Winter Park (Cincinnati U. 1970)
Schimpff, Robert D., Gainesville (Florida U. 1966)
Smith, Wesley O., Pensacola (Tulane 1969)
Southern, Donald E., Orlando (Va. U. 1964)
Steiner, Jerome, Dover Plains, N. Y. (N. Y. Downstate 1963)
Sullivan, Patrick J., Miami (George Washington U. 1970)

Torres, Claudio, LaGrange, Ill. (Illinois U. 1968)
Trezza, James T., Staten Island, N. Y. (N. J. Med. Coll. 1966)
Turek, Charles D., Chicago (Northwestern 1966)

Wald, Robert J., Key West (N. Y. Upstate 1967)
Wasserman, Elliot T., Fort Leonard Wood, Mo. (Tufts 1967)
Wasserman, Norman H., Buffalo, N. Y. (Chicago M. S. 1967)
Waxler, Edward B., Waycross, Ga. (N. Y. U. 1965)
Weiss, Barry R., Tyndall AFB (N. Y. Buffalo 1967)
Weiss, Charles J., Gainesville (Chicago M. S. 1970)
Weitzner, Ronald I., Miami (Chicago M. S. 1970)
White, Ronald P., Columbus, Ohio (Ohio U. 1970)
Woodward, Craig D., Miami (George Washington U. 1970)

Yannuzzi, Lawrence A., New York (Boston U. 1964)
Yutani, Frederick M., Fort Lee, Va. (George Washington U. 1966)

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Woman's Auxiliary



Sixth Annual Benefit Art Show

Florida Medical Association Annual Meeting
Diplomat Hotel, Hollywood
May 3-6, 1972

Exhibit Rules and Regulations

READ RULES CAREFULLY

1. All entries must be original work.
2. Pictures must be framed and wired for hanging. Stands will be provided for sculpture, etc.
3. Each entry must have a typed card indicating Name, Address, Medium, Dimensions and Title. Please list price if entry is for sale; otherwise, mark not for sale (NFS).
4. Only one artist's name should be listed for each registration slip. Additional application blanks may be obtained from Mrs. Ronald J. Centrone, Chairman.
5. A registration fee of $10.00 will be charged for each entry. Entry fees are tax deductible.
6. All registration slips and checks must be sent in together no later than April 26, 1972.
7. All pre-registered entries are to be delivered by hand to the Exhibit Hall, at the Diplomat Hotel, Hollywood, no later than 4:00 P.M., Wednesday, May 3. Shipped entries will be refused.
8. All entries must remain on exhibition until 12:00 P.M. on Saturday, May 6.
9. We will not be held responsible for entries not picked up before 1:00 P.M., Saturday, May 6.
10. Doctors, their wives and children are eligible to enter. Entry fees will be donations to the St. Augustine Medical Museum.

Kindly enter my registration to show in the Benefit Art Show.

Fee of $_____ for_____ entries is enclosed.

I agree to abide by the rules and regulations for exhibiting material in the show.

Name _____

Address _____

City _____County _____

I will be showing in the following categories: Please check (X) appropriate category (categories) applying to your entry (entries).

() A. Painting. Include any media in color: acrylic, oil, casein, collage, water color, pastel, etc.

() B. Graphics. Include pen and ink, charcoal, photography, etc.

() C. Crafts. Include sculpture, pottery, ceramics, mosaic, weaving, jewelry, etc.

() I am the son/daughter of a Florida physician. Age _____

Judges will give "Awards of Merit" and "Best in Show." An "Editor's Award" will be given and the winning entry will be used on the cover of a future issue of the FMA Journal.

A registration fee of $10.00 will be charged for each entry. Make checks payable to:

Mrs. Ronald J. Centrone, Chairman
4705 N.E. 25th Avenue
Fort Lauderdale, Florida 33308

REGISTRATION DEADLINE APRIL 26, 1972.

Classified Ads

physicians wanted

General Practitioners

WANTED: ASSOCIATE FOR FAMILY PRACTITIONER in Fort Lauderdale area. Age 34. Florida license required. No obstetrics or major surgery. Financial arrangements open. Send resume to C-530, P.O. Box 2411, Jacksonville, Florida 32203.

FAMILY PHYSICIAN AND INTERNIST WANTED: To join specialty group in rapidly growing area. Salary and partnership negotiable. Excellent 450-bed new hospital. Contact James Morgan, M.D., 400 Avenue "K," S.E., Winter Haven, Florida 33880.

WANTED: Family physician, internist to join established group in one of fastest growing areas of nation on Florida West coast. Group now consists of diplomate ABFP, board surgeon, board eligible surgeon and 2 family physicians who are AOA. Above average guarantee against gross. 46-week year. Call or write or visit James M. Marlowe, M.D., P.O. Box 1058, New Port Richey, Florida 33552. Phone (813) 849-2238.

GENERAL PRACTITIONER OR INTERNIST to associate with busy established medical doctor. Clinic type building, x-ray and full laboratory. Salary first year, then partnership. Rapidly growing area on Gulf Coast. Contact M. J. Hetman, M.D., Beach Medical Clinic, Fort Myers Beach, Florida 33931.

Specialists

INTERNIST, UROLOGIST, GP's.: Outstanding opportunities in progressive nonurban community serving 20,000. Write John H. Parker, M.D., Chief of Staff, Doctors Memorial Hospital, Perry, Florida 32347.

INTERNIST WANTED: For association, greater Miami area, Please send curriculum vitae to C-524, P.O. Box 2411, Jacksonville, Florida 32203.

CHIEF RADIOLOGIST WANTED: For 520 bed accredited community hospital in Hollywood, Florida. Write Dr. Marvin S. Allen, Chief of Staff, Memorial Hospital, 3501 Johnson Street.

INTERNIST WANTED: Board eligible or certified, preferably with subspecialty, interest in hematology and/or gastroenterology to join flourishing practice in Fort Lauderdale area. Excellent salary and fringe benefits first year, leading to association. Must have Florida license. Please phone (305) 565-6434.

INTERNIST WANTED: Board eligible or certified, married, military service completed. Join growing busy internal medical practice. Suburban Miami area. Write Box C-527, P.O. Box 2411, Jacksonville, Florida 32203.

NEEDED IMMEDIATELY: Four internists, urologists, orthopedists and general surgeon for practice in area of rapid growth. Modern local hospitals. Contact Warren A. Clark, M.D., P.O. Box 1376, New Port Richey, Florida 33552. Phone (813) 849-1386.

OPPORTUNITY FOR INTERNIST: Board certified or eligible, interested in cardiology. Service area 35,000 in Northeast Florida. Sixty-eight bed general hospital with two bed coronary care unit. (JCAH) Contact Administrator, The Beaches Hospital, Jacksonville Beach, Florida 32250 or phone (904) 246-6731.

CHIEF PATHOLOGIST WANTED: For 520 bed accredited community hospital in Hollywood, Florida. Write Dr. Marvin S. Allen, Chief of Staff, Memorial Hospital, 3501 Johnson Street.

WANTED: Urologist, Ob-Gyn, Internist, orthopaedist to join expanding group of young, well qualified family physicians and surgeons now consisting of diplomate ABFP, board certified surgeon, board eligible surgeon and 2 family physicians who are AOA. Service area of about 80,000 served by 10 M.D.s; one of fastest growing in entire nation. Two hospitals with open staffs. Additional office space soon available. Above average guarantee against gross. 46-week year. Call or write or visit James M. Marlowe, M.D., P.O. Box 1058, New Port Richey, Florida 33552. Phone (813) 849-2238.

ADDITIONAL PHYSICIANS URGENTLY NEEDED: GP, internal medicine, obstetrics, pediatrics, and general surgery. Modern office immediately available. Contact I. B. Price, M.D., P.O. Box 819, Quincy, Florida 32351.

(Continued)

Miscellaneous

PHYSICIANS WANTED IN FLORIDA, DIVISION OF MENTAL HEALTH: Positions are available for qualified physicians (Florida license not required). General practitioners, internists, surgeons, psychiatrists—in the hospital facilities of the Division of Mental Health. Interest, accompanied by a curriculum vitae, should be directed to E. Arthur Larson, M.D., Deputy Director for Hospitals and Institutes, Division of Mental Health, 200 East Gaines Street, Room 425, Tallahassee, Florida 32304.

WANTED IMMEDIATELY: Private emergency room physician. Corporate group needs fifth physician in teaching hospital, Orlando, Florida. Prefer GP. Florida license required. Contact Bruce S. Webster, M.D. (305) 647-5728 or Robert Gay, M.D. (305) 422-0159.

PHYSICIANS NEEDED: Tallahassee, Leon County, Northwest. General practitioners, internists and pediatricians in particular. Inquiries regarding practice in this community can be forwarded to J. Orson Smith Jr., M.D., Chairman, Physician Procurement Committee, 1433 Miccosukee Rd., Tallahassee, Fla. 32303. Phone (904) 877-1145.

DUNEDIN, Pinellas County, middle west coast, Clearwater area. Thirty-six physician multispecialty group seeking internist-gastroenterologist, neurologist, pathologist, obstetrician-gynecologist, GP, and emergency room physician. Affiliated general hospital just expanded to 308 beds. Clinic expansion to be completed January 1972. Long range plans for 650 beds and 75-physician clinic. No investment required. Contact Donald M. Schroder, administrator, Mease Hospital and Clinic, P.O. Box 760, Dunedin 33528, phone (813) 733-1111.

PHYSICIANS WANTED: With Florida licenses to serve on emergency medical vehicles operated by the city of Miami Beach. Guaranteed annual income of $30,000. Apply by mail or in person, City Hall, Personnel Department, 1130 Washington Avenue, Miami Beach, Florida 33139.

WANTED: in Clearwater, Florida area. M.D.s, age 40 or over with Florida license, in reasonable health, interested in primary care. Salary plus percentage and other benefits. Flexible hours. Your own hospital practice optional. Write or call D. W. Crockett, M.D., 1887 W. Bay Dr., Largo, Florida 33560. Phone (813) 581-2845.

MEDICAL DIRECTOR FOR RESPIRATORY CARE UNIT WANTED: For 520 bed accredited community hospital in Hollywood, Florida. Write Dr. Marvin S. Allen, Chief of Staff, Memorial Hospital, 3501 Johnson Street.

FAMILY PRACTITIONERS NEEDED: A team of competent physicians can be assured of a good practice in a growing community where the need for doctors is acute and growing each day. It affords gracious living, with many recreational facilities nearby and a fine place to raise a family in high, middle-class surroundings. WHERE: Tequesta, Florida (18 miles north of Palm Beach). POPULATION: 1971—11,000; 1975—15,000; 1980—20,000 within a 2 x 4 mile area. COMMUNITY: Largely residential with high, middle income families with children. About 24% over 65. HOSPITALS: Palm Beach Gardens Community Hospital—9 miles; Good Samaritan Hospital—18 miles, and St. Mary's Hospital—18 miles. PRESENTLY: Two (2) M.D.'s for 12,000 people. Contact—John Giba, 78 Fairview East, Tequesta, Florida 33458. (305) 746-7693.

situations wanted

POSITION WANTED: 50 year old general practitioner with Florida license moving to Florida in July desires emergency room opening or association with another GP on west coast of Florida. Robert H. Wiese, M.D., 460 Saratoga Road, Scotia, N.Y. 12302.

INTERNIST: Board eligible, Age 31. Subspecialty endocrinology plus one year cardiology fellowship. Former chief resident, university trained, completed military obligations, Florida licensed. Would like to join group practice or partnership in internal medicine. Would prefer teaching appointment at community hospital combined with private practice available. Write C-532, P.O. Box 2411, Jacksonville, Florida 32203.

WANTED: Full time hospital or medical school surgical position, director of surgery, chief of staff, director of medical education, emergency service, intensive care service. Fully qualified in administrative, clinical and teaching surgery, highly desirable, 46 years old. Curriculum vitae on request. Write C-519, P.O. Box 2411, Jacksonville, Florida 32203.

POSITION WANTED: Private surgical practice, associate and assistant. Highly qualified and very desirable but position must not exceed 40 hours/week. Curriculum vitae on request. Write C-520, P.O. Box 2411, Jacksonville, Florida 32203.

PATHOLOGIST: Strong background large hospital laboratory direction, academic appointment, past president state pathology society among others, seeking challenge similar category or related administrative fields. Local references. Write C-531, P.O. Box 2411, Jacksonville, Florida 32203.

practices available

OB-GYN. PRACTICE, EQUIPMENT AND FURNISHINGS FOR SALE: Located in central area of Coral Gables. Approximately 1,000 sq. ft. consisting of reception room, business office, two examining rooms, laboratory, powder room and consultation room. New lease available. For further information write R. B. Chrisman Jr., M.D., 819 North Greenway Drive, Coral Gables, Florida 33134.

INTERNAL MEDICINE PRACTICE FOR SALE: In outstanding location of Fort Lauderdale, Florida (physician deceased). Gross $70,000 yearly. Combination nurse and secretary will remain in the office. If interested, please contact Mrs. Olga Garcia, 726 Northeast 26th Avenue, Fort Lauderdale, Florida 33304 or phone (305) 563-8022.

PSYCHIATRIST: Take over thriving psychiatric practice for cost of furnishings and equipment. Excellent location leading South Florida East Coast city. Write C-526, P.O. Box 2411, Jacksonville, Florida 32203.

real estate

EXCELLENT OFFICE SPACE AVAILABLE: In the Five Points Medical Center, Oak and Lomax Sts., Jacksonville, Fla. 32204. All utilities and services furnished. For information please call Dr. Max Mendelson at 355-5150.

HOLLYWOOD—SPACE AVAILABLE. New Medical Offices. Will partition. Ideal location—Hollywood Boulevard. Riverside Military Academy Circle. For information call: Dr. Alvin Fisher, 3816 Hollywood Blvd., Hollywood, Florida. Phone (305) 989-9800.

OUTSTANDING LOCATION FOR SPECIALIST: St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville 32207. Phone (904) 398-5500.

EXCELLENT OFFICE SPACE AVAILABLE: Gulfport-St. Petersburg. 1,500 sq. ft., eleven rooms, lab., previously occupied by two M.D.s. Present occupants of building, two dentists, one optometrist. Write or call Elmer J. Kouba, D.D.S., 5028 Gulfport Blvd., S., Gulfport, Florida 33707. Phone (813) 343-6197.

LEASING PRIVATE SUITES: Orlando-residential area near new hospital needs GP or pediatrician. Completed one story medical building—trees, staff parking, rear entrance, ready now. Contact Marcus O. Williams, D.M.D., 201 Maitland Ave., Altamonte Springs, Florida 32701.

OWN YOUR OWN OFFICE IN CONDOMINIUM PROFESSIONAL BUILDING in downtown Winter Park. Contact Stanley Duane, 200 East New England Avenue, Winter Park, Florida 32789. Phone (305) 644-4808.

MEDICAL ARTS CENTER: Unique and modern, under construction. Specialty 3-man expansion wing planned. Area needs ENT, internist, ophthalmologist and urologist. Randall B. Whitney, M.D., 408 Highway 19-Alt., Mount Dora, Florida 32757.

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Next Annual Meeting: May 3-7, 1972, Hollywood

VOL. 59, NO. 4

JFMA

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

APRIL 1972

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May 3-7, 1972 — Hollywood
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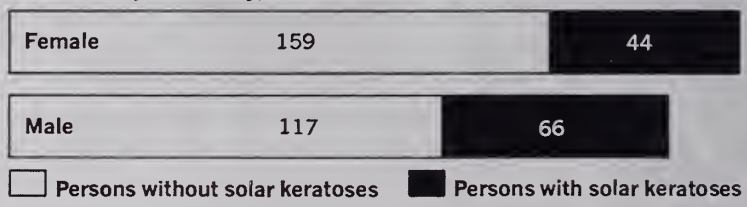
What it means to live and work in Tipton County, Tennessee

Persons who are white and over 40 have one chance in four of having solar keratoses... which may be premalignant

An epidemiologic study* conducted in Tipton County, Tennessee, revealed that 28.5% of white persons over 40 had solar keratoses; most had multiple lesions. Cluster sampling projected an estimated prevalence of 32.5% for white males and 19.5% for white females.

Though this is an unusually high percentage of affected persons, these lesions can occur in any white population, wherever people work or play out of doors.

Prevalence of solar keratoses in white persons over 40 in Tipton County, Tennessee



*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.



olar, actinic, senile keratoses

alled by many names, the typical lesion is flat slightly elevated, brownish or reddish in lor, papular, dry, adherent, rough, sharply fined; usually multiple lesions, chiefly on posed portions of the skin.

equence/selectivity of response

rythema in areas of lesions may begin after veral days of therapy; height of reaction nly in affected areas)* usually occurs within o weeks, declining after discontinuation of erapy. Since this response is so predictable, ions that do not respond should be biopsied rule out the presence of a frank neoplasm.

osmetic results

smetic results are highly favorable. Incince of scarring is low—important with multi- facial lesions. Efudex should be applied th care near the eyes, nose and mouth.

% cream–a Roche exclusive

nly Roche formulates the 5% cream... gh in patient acceptability... high in clinical icacy, especially for lesions of hands and rearms... economical.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

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Owned and published by the Florida Medical Association, Inc., P. Box 2411, Jacksonville, Florida 32203. Subscription price is $. (plus 28 cents sales tax) per year; single issue 70 cents (plus sales tax). The Journal is not responsible for the opinions and st ments of its contributors. Published monthly at Jacksonville, Flor Accepted for mailing at special rate of postage provided for in Sec 1103. Act of Congress of October 3, 1917; authorized October 1918. Second-class postage paid at Jacksonville, Florida.

APRIL COVER—Bronze bust of Madame Renoi by Auguste Renoir (1841-1919) done in 1916 and given to the Cumme Gallery of A t, Jacksonville by Mr. and Mrs. Edward Wood Lane Jr., 1971.

President's Page



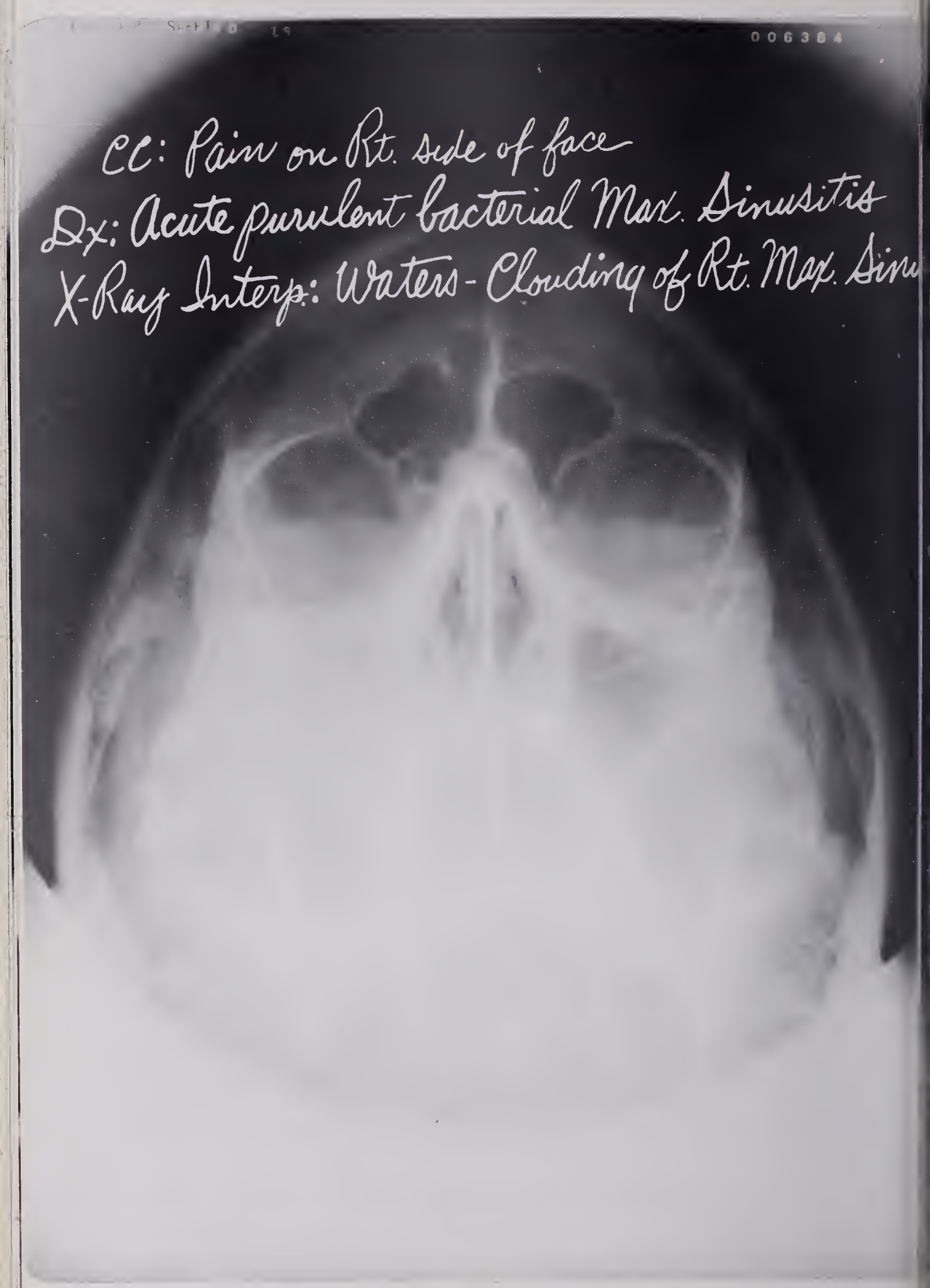
Your Responsibility

Our profession has a unique position of privilege in modern society; and indeed, in some quarters we are known as "The Privileged Minority," but this is only because our fellow men must depend on us for the most essential element of life—mainly physicial and mental wellbeing. Thus, our privileges are not and will not be accorded to us as individuals, but as members of a great profession with knowledge and skills belonging to the community in which we live, rather than to ourselves as individuals.

If this knowledge and these skills are to be maintained for the common good, it can best be said that all people have a right to these services. The physician who adequately delivers these skills and services knows full well that it must be in a climate in which the conditions for performing these services are optimum. It is his responsibility to see that these conditions are maintained. So actually, the physician has two great responsibilities: first, to maintain his professional skill; and second, to exert every possible influence to see that the climate in which these services are delivered is a thoroughly just one.

This is the time when many of our foundations upon which medical care is delivered are being shaken by every social planner in the country, including our own state. We must do everything in our power to see that our voices are heard. This can best be done in a professional organization such as the Florida Medical Association. This is the organization which sets the standards of professional care, that establishes the means to audit and assure standards of medical care to all citizens of our state, and the organization to which our legislators turn for advice and guidance; the organization which tries to represent all segments of medicine. Elsewhere in this issue of *The Journal* there is a report of the Annual Meeting to be held in May at the Hollywood-Diplomat. I urge all of you who can possibly do so to attend this meeting, for where else can you find an organization that gives you a floor for your opinions and representation in development of policy of the only truly representative group of physicians in the state? We also desperately need your advice and counsel, and I warn you that this is not the time to stand on the sidelines wringing your hands or offering words of encouragement. We want you to become part of the Florida Medical Association by being present.

J. K. Hurt M.D.



X-ray provided by Manhattan Eye, Ear and Throat Hospital

¿Habla español?

not, the new Rocom Health History Questionnaire asks questions in Spanish...

¿Le molestan coyunturas o músculos rígidos o dolorosos?	1.	Sí ✕	No
¿Se le hinchan las coyunturas?	2.	Sí	No ✕
¿Le molestan dolores en la espalda u hombros?	3.	Sí ✕	No
¿Le duelen los pies con frecuencia?	4.	Sí	No ✕
¿Está desabilitado en alguna manera?	5.	Sí	No ✕
¿Tiene algún problema con su piel?	6.	Sí	No ✕
¿Le pica o quema la piel?	7.	Sí	No ✕
¿Sangra por largo tiempo cuando se hace una pequeña cortadura?	8.	Sí	No ✕
¿Se lastima facilmente formando un cardenal o morete?	9.	Sí	No ✕
¿Se ha desmayado o se ha sentido como que se va a desmayar?	10.	Sí	No ✕
¿Tiene alguna parte del cuerpo siempre adormecida?	11.	Sí ✕	No
¿Ha tenido alguna vez convulciones?	12.	Sí	No ✕
¿Le ha cambiado ultimamente su letra al escribir?	13.	Sí	No ✕
¿Tiene tendencia a temblar o menearse mucho?	14.	Sí	No ✕
¿Se pone nervioso en presencia de personas extrañas?	15.	Sí ✕	No
¿Se le hace difícil tomar decisiones?	16.	Sí ✕	No
¿Se le hace difícil concentrar o recordar?	17.	Sí ✕	No
¿Se siente solo o deprimido?	18.	Sí	No ✕
¿Llora a menudo?	19.	Sí	No ✕
¿Diría usted que tiene una perspectiva irremediable?	20.	Sí	No ✕
¿Tiene dificultad en relajar o reposar?	21.	Sí ✕	No
¿Tiende a preocuparse demasiado?	22.	Sí ✕	No
¿Le molestan o asustan algunos sueños o pensamientos?	23.	Sí	No ✕
¿Tiende a ser tímido o sensitivo?	24.	Sí	No ✕
¿Se molesta mucho cuando lo critican?	25.	Sí ✕	No
¿Pierde el genio con frecuencia?	26.	Sí ✕	No
¿Cosas pequeñas lo hacen molestar?	27.	Sí ✕	No
¿Le molesta cualquier trabajo o problemas familiares?	28.	Sí	No ✕
¿Tiene algún problema con su vida sexual?	29.	Sí	No ✕
¿Ha considerado alguna vez suicidarse?	30.	Sí	No ✕
¿Ha deseado alguna vez, o buscado, ayuda psiquiatrica?	31.	Sí ✕	No

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provides answers in English

13. MUSCULOSKELETAL
- ✕ aching muscles or joints
- ___ swollen joints
- ✕ back or shoulder pains
- ___ painful feet
- ___ handicapped

14. SKIN
- ___ skin problems
- ___ itching or burning skin
- ___ bleeds easily
- ___ bruises easily

15. NEUROLOGICAL
- ___ faintness
- ✕ numbness
- ___ convulsions
- ___ change in handwriting
- ___ trembles

16. MOOD
- ✕ nervous with strangers
- ✕ difficulty making decisions
- ✕ lack of concentration or memory
- ___ lonely or depressed
- ___ cries often
- ___ hopeless outlook
- ✕ difficulty relaxing
- ✕ worries a lot
- ___ frightening dreams or thoughts
- ___ shy or sensitive
- ✕ dislikes criticism
- ✕ loses temper
- ✕ annoyed by little things
- ___ work or family problems
- ___ sexual difficulties
- ___ considered suicide
- ✕ desired psychiatric help

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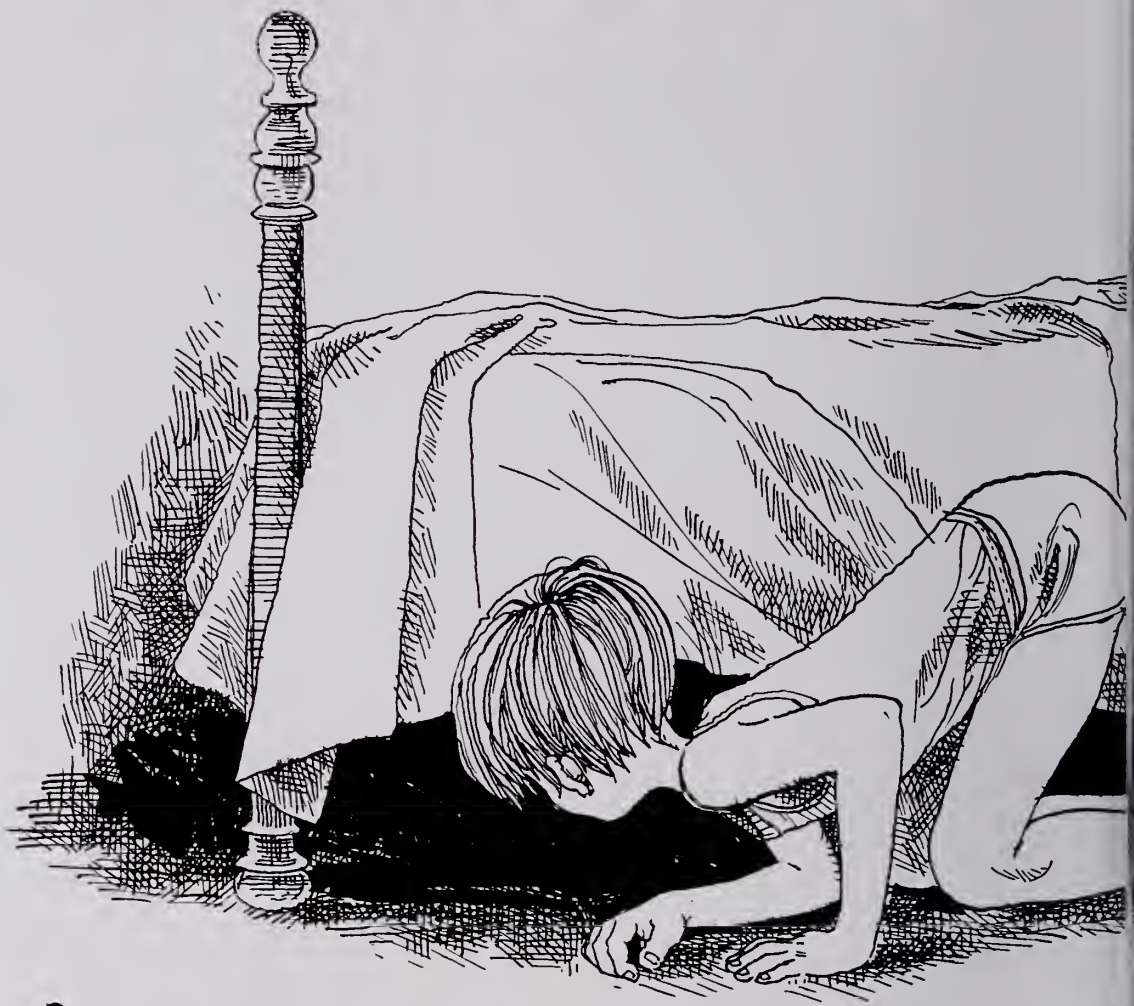
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Highly effective. Active against pinworm...and roundworm.

Non-staining. Doesn't stain teeth or oral mucosa on ingestion. Doesn't stain stools, clothing or linen.

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Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia

Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lbs. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day; and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices. Because of limited data on repeated doses, no recommendations can be made

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg pyrantel base per ml., supplied in 60 cc. bottles.

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(pyrantel pamoate)

equivalent to 50 mg pyrantel/ml

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Contraindications: Hypersensitivity to barbiturates or belladonna alkaloids, glaucoma, advanced renal or hepatic disease.
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Dosage: Adults: One or two tablets three or four times daily. Dosage can be adjusted depending on diagnosis and severity of symptoms. Children 2 to 12 years: One half or one tablet three or four times daily. Tablets may be chewed or swallowed with liquids.

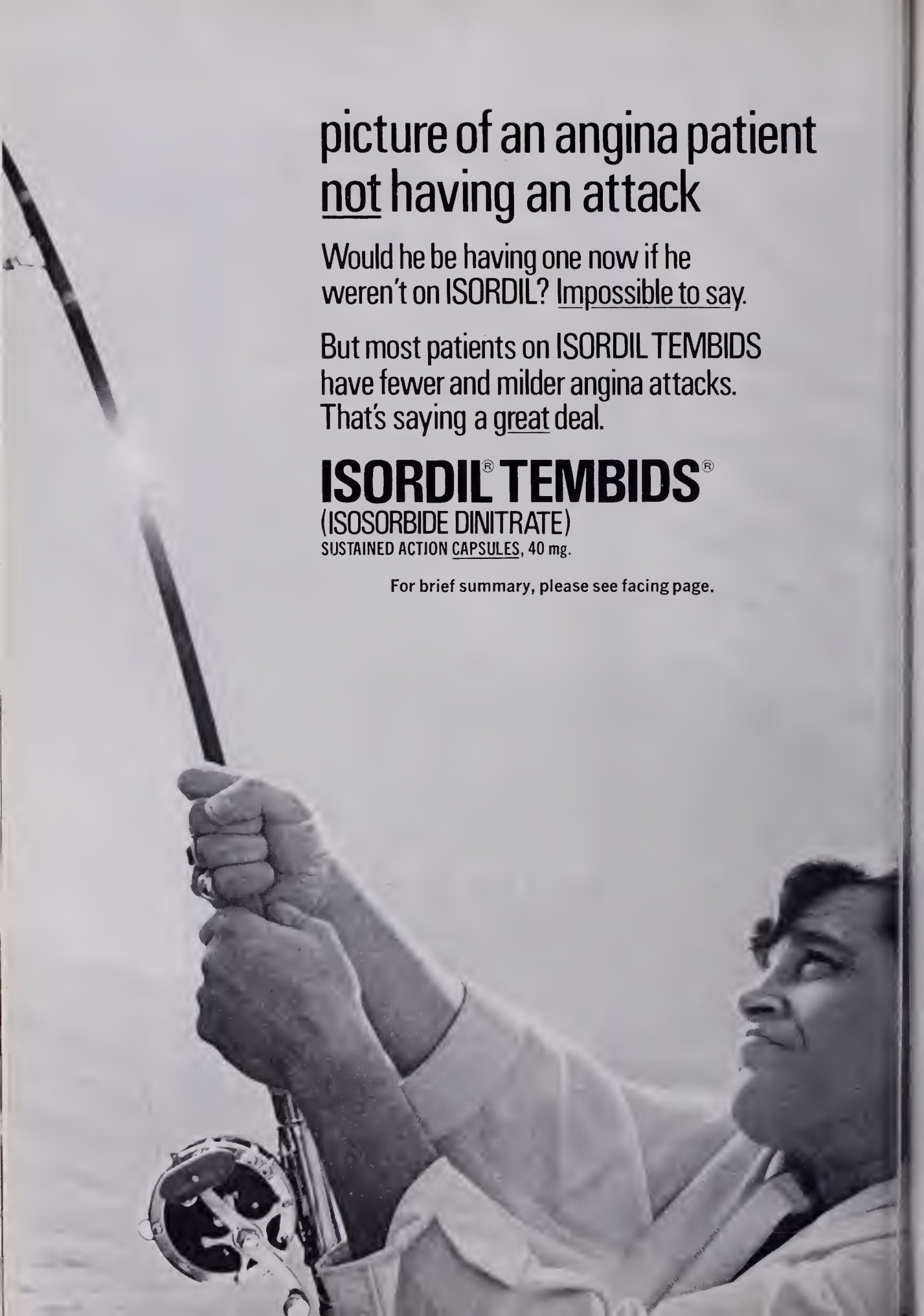
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to move,
and the Latin **sedatus,**
to calm)

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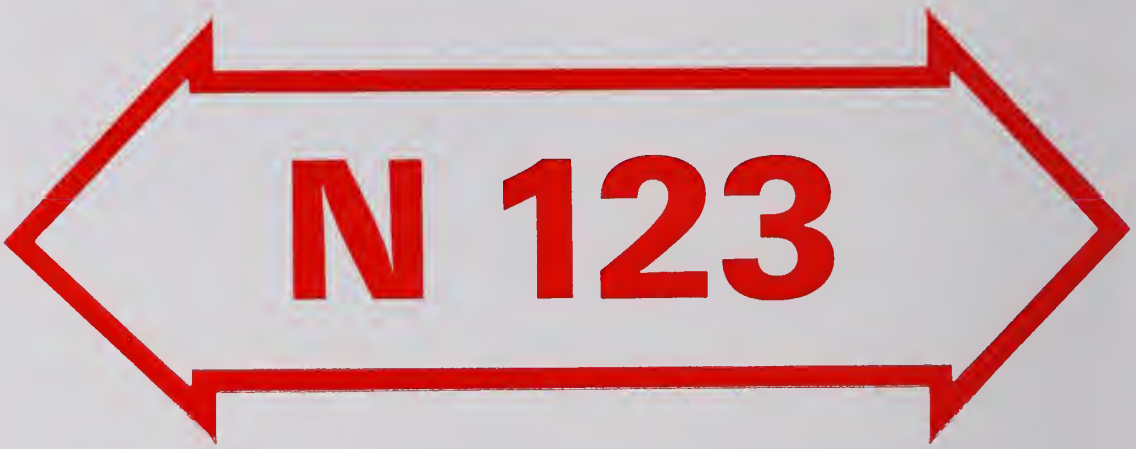
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Dean's Page

The Medical Dean

Donn L. Smith, M.D.

This short dissertation concerning the challenges and problems which face the Medical Dean is written with the faint hope that it may be of interest to some, subject to minimal misinterpretation and somewhat informative. Several significant areas of activity produce major challenges and opportunities and, inevitably, many difficult problems. People, facilities, money and the Dean's approach to medical education represent the major elements of the complex equation which is presented daily for solution. Probably the most important and fascinating, yet difficult, variable with which one must deal with in an effective manner are the people involved, medical students, faculty, practicing physicians, university administrators, governmental personnel, and hospital boards and officials plus the public.

For me, the student receives first priority, but it is clear that the other groups are involved in a very critical way and their concerns and activities must be given first rate consideration. The well informed and important opinions and attitudes of these several responsible groups of people must be coordinated and welded into a meaningful and productive educational enterprise. This process represents a critical and essential segment of the Dean's responsibility to his institution. The amount of time and effort that must be expended in this area of activity leads to a highly instructional and maturing experience for the Dean. In recent years, governance of the institution has become an increasingly complex and emotionally-charged segment of the people-oriented part of the equation. Students and faculty alike insist on and have achieved a larger voice in the conduct of the affairs in many of the colleges of medicine. In this context, the Dean must learn to move forward on a very thin line which separates meaningful student and faculty involvement from a total shambles of everyone doing his thing without regard for the long term best interest of the institution; indeed, this matter represents a delicate but explosive issue in which the welfare of the institution as a whole must be balanced against the rights of the individual. Successful medical school administrators are learning to handle this problem but a fair number of eggs have been broken in the making of the omelette. Physical facilities, while perhaps secondary in importance, require substantial attention. Recruitment of able students and faculty are effected as are the mechanics of teaching and research. Although an excellent physical plant does not assure a high quality school, poor or inadequate facilities make it increasingly difficult to achieve the high standards of teaching and research that must be attained in a superior institution.

While it is true that money cannot be taken with you nor can it assure happiness, it is equally certain that modern medical education cannot progress very far without it. Some financial adversity and a lean and hungry approach to the expenditure of public funds may be productive of strenuous efforts to survive and grow, but there is a pretty well defined limit of fiscal capability below which the major thrust is simply to survive, with no significant progress towards excellence possible. The Dean's problem in this area, is to somehow maintain adequate funding patterns, furthermore, he must extract maximum value for each dollar spent and make the hard decisions relative to the distribution of limited funds among the many important and worthwhile academic functions. This is perhaps the least attractive part of the Dean's work. An acceptable blend of intuition, conscious judgment, evaluation and intellectual toughness is required just to survive the budget process.

The Dean's concept and philosophy of medical education and its balance vis-a-vis research may well provide the challenge and a set of prob-

Dr. Smith is Director of the Medical Center and Dean of the College of Medicine, University of South Florida, Tampa.

lems of a most rigorous nature, and at times in depressing circumstances. If his standards and objectives are aimed towards true excellence in education he must be prepared to exert maximum effort in leadership and persuasive manipulation in numerous directions more or less simultaneously. Patience, ability to listen to special pleadings and considerable experience are required; it is in this area that the Dean may leave his mark on the school and its graduates. It is also the area in which the major frustrations occur inasmuch as adequate means, personnel and space are not uniformly available and an accurate and realistic assessment of the potential of the school must be made and constantly updated. In this frame of reference adequate planning and alternative courses of action must be projected; if the plans fit the problems to be solved and the potential remains unimpaired, then a variable proportion of the goals related to excellence may be achieved.

Should the foregoing discussion lead to the premise that the Dean's job is a difficult and nearly impossible one, it is only fair to report that it is also an exciting and rewarding occupation. Intellectual stimulation, adequate opportunity to innovate and some visible progress can be major and lasting benefits. One is in daily contact with many able and delightful people, a few invaluable and lasting friendships come into being and some highly respected and stimulating adversaries emerge.

Although the occupation is hazardous and the tenure always uncertain and often short, in balance, it is a reasonably useful type of work in which to engage.

One would hope that in time a more reasonably structured administrative setting might be developed in which the job would become a little less demanding and somewhat more stable in terms of continuity. Under such circumstances a more productive and less crisis-oriented performance would be possible.

▶ Dr. Smith, University of South Florida, Tampa 33620.

Pre-Sate®
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CAUTION: Federal law prohibits dispensing without prescription.
Indications: Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (*i.e.*, several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.
Contraindications: Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.
Warnings: When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.
Drug Dependence: Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.
Usage In Pregnancy: The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.
Usage In Children: Not recommended for use in children under 12 years of age.
Precautions: In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorexic agent and a restrictive dietary regimen.
Adverse Reactions: Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.
Dosage and Administration: The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.
Overdosage: Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.
Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.
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An orally active hypoglycemic agent principally indicated in relatively mild, adult, maturity-onset, non-ketotic diabetes; also, as a supplement to insulin therapy in selected diabetic patients, it may effect a stabilization of labile diabetes and reduce insulin requirements. Certain patients intolerant to chlorpropamide therapy at usual therapeutic doses have subsequently been successfully managed with Orinase (tolbutamide).

Use in mild asymptomatic diabetic patients with abnormal glucose tolerance tests not responding to diet therapy may result in improvement of the glucose tolerance test.

Use in conjunction with phenformin is indicated when optimal control is not obtained with Orinase or phenformin alone.

Contraindications: Orinase alone is not effective in juvenile or growth-onset diabetes nor in unstable brittle diabetes where insulin therapy is required.

Orinase should not be used: when diabetes is complicated by acidosis, ketosis, or coma, or when a history of repeated bouts of acidosis or coma is obtained; in the presence of other acute complications such as fever, severe trauma, or infections; and in patients with severe renal insufficiency. Insulin is indicated in these circumstances.

Pregnancy Warning: The safety and usefulness of Orinase during pregnancy has not been established either from the standpoint of the mother or the fetus. Animal studies have demonstrated feticidal and teratogenic effects of doses of 1,000-2,500 mg./kg./day, but application to human subjects unknown. Therefore, Orinase is not recommended for the pregnant diabetic, and when administering Orinase to women of childbearing age, these facts should be borne in mind.

Precautions: Diagnostic and therapeutic measures necess for optimal control with insulin are also necessary with Orin The patient on Orinase must be fully instructed: about nature of his disease; how to prevent and detect complicati how to control his condition; not to neglect dietary restricti develop a careless attitude or disregard instructions relativ body weight, exercise, personal hygiene, and avoidance of fection; how to recognize and counteract impending hypo cemia; how and when to test for glycosuria and ketonuria; to use insulin; and to report to the physician immediately i does not feel as well as usual.

Caution, very close observation, and careful adjustmen dose are necessary when: insulin is withdrawn during the period in order to avoid ketosis, acidosis, and coma; thia diuretics are administered which may result in aggravatio diabetic state and increased tolbutamide requirement, ter rary loss of control, or even secondary failure; treating pati with impaired hepatic and/or renal function and debilitated, nourished, or semistarved patients in order to avoid severe h glycemia which may require corrective therapy over se days; and treating patients with severe trauma, infection, or gical procedures where temporary return to insulin or add of insulin may be necessary. Response to tolbutamide is di ished in patients receiving therapy with beta blocking ag

As some diabetics are not suitable candidates, it is esse that the physician familiarize himself with the indications, of application, and selection of patients for therapy.

Patients must be under continuous medical supervision, during the initial test period should communicate with the p

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(tolbutamide, Upjohn)

ian daily, and during the first month report at least once weekly r physical examination and definitive evaluation. After a month, xaminations are recommended monthly or as indicated. Ap- earance of ketonuria, increase in glycosuria, unsatisfactory wering or persistent elevation of blood sugar, or failure to btain and hold clinical improvement indicate nonresponsive- ess to Orinase (tolbutamide). Orinase does not obviate need for naintaining standard diet regulation. Uncooperative patients hould be considered unsuitable for therapy. Prescriptions should e refilled only on specific instruction of physician. In treating ild asymptomatic diabetic patients with abnormal glucose olerance, glucose tolerance tests should be obtained at three- o six-month intervals. Orinase is not an oral insulin or a substi- ute for insulin and must not be used as sole therapy in juvenile liabetes or in diabetes complicated by acidosis or coma where nsulin is indispensable.

If phenformin is prescribed in combination with Orinase, ap- ropriate package literature should be consulted.

Adverse Reactions: Severe hypoglycemia, though uncommon, nay occur and may mimic acute neurologic disorders such as cerebral thrombosis. Certain factors such as hepatic and renal disease, malnutrition, advanced age, alcohol ingestion, and adrenal and pituitary insufficiency may predispose to hypogly- cemia and certain drugs such as insulin, phenformin, sulfona- mides, oxyphenbutazone, salicylates, probenecid, monamine oxidase inhibitors, phenylbutazone, bishydroxycoumarin, and phenyramidol may prolong or enhance the action of Orinase and increase risk of hypoglycemia. Orinase long-term therapy has been reported to cause reduction in RAI uptake without producing clinical hypothyroidism or thyroid enlargement and at high doses is mildly goitrogenic in animals. Photosensitivity reactions, disulfiram-like reactions after alcohol ingestion, and false-positive tests for urine albumin have been reported.

Although usually not serious, gastrointestinal disturbances (nausea, epigastric fullness, and heartburn) and headache appear to be dose related and frequently disappear with reduction of dose or administration with meals. Allergic skin reactions (pruritus, erythema, urticaria, and morbilliform or maculopapular eruptions) are transient, usually not serious, and frequently disappear with continued administration. Orinase should be discontinued if skin reactions persist. Recent reports indicate that long-term use of Orinase has no appreciable effect on body weight.

Orinase appears to be remarkably free from gross clinical toxicity: crystalluria or other renal abnormalities have not been observed; incidence of liver dysfunction is remarkably low and jaundice has been rare and cleared readily on discontinuation of drug (carcinoma of the pancreas or other biliary obstruction should be ruled out in persistent jaundice); leukopenia; agranulocytosis; thrombocytopenia; hemolytic anemia; aplastic anemia; pancytopenia; and hepatic porphyria and porphyria cutanea tarda have been reported.

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PRECAUTION: Do not use when symptoms of appendicitis are present and discontinue use if skin rash appears. Dependence on laxatives can result from continued use.

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– George Sarton, from "The History of Medicine Versus the History of Art"

Should nongovernment scientists and physicians play a role in drug regulation?

Opinion

Results of a questionnaire to 7000 physicians:

82.8%
Physicians should play a role

78.3%
Independent scientists should play a role

69.8%
Medical academicians should play a role

Opinion & Dialogue

Dialog

Should nongovernment scientists and physicians play a role in drug regulation?

Doctor of Medicine

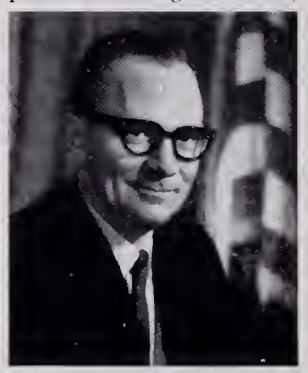
Herbert L. Ley, Jr., M.D., M.P.H., Formerly Commissioner, F.D.A. (1968-1969) Currently Medical Consultant

In order for drug regulation to be effective, participation in the regulatory process from nongovernment physicians and scientists must be encouraged. Without such involvement, there will continue to be a high degree of controversy surrounding any regulations promulgated by the Food and Drug Administration.

There are two areas in which participation and communication by nongovernment physicians and scientists could significantly improve the process of regulation. First, scientists and physicians throughout the country could become involved in consulting relationships with the Food and Drug Administration in important scientific areas while regulatory policies are being evolved. If nongovernment professionals could bring their expertise and experience to bear early in the decision-making process, they would have less reason to criticize the final outcome.

Secondly, practicing physicians, academic physicians, and academic-based scientists could make it their business to comment on proposed regulations appearing in the Federal Register. Ideally, a system could be instituted whereby medical, scientific and technical people could see the Federal Register regularly, and provide the Food and Drug Administration with a body of opinion that has so far gone unheard. The FDA is caught among pressures from industry, Congress, the Presidential Administration and consumers. It should also feel pressures from practicing physicians and scientists.

In order to become more involved in these stages of the drug regulatory process, nongovernment physicians and scientists should begin to exercise their influence through their respective professional organizations,



state and national medical societies, and specialty groups. Logically, a letter from these organizations representing a collective opinion has far greater weight in the regulatory process than individual letters. If the Food and Drug Administration receives opinions from these organizations early, before a regulation gets into the Federal Register, they are in a good position to respond with further study and review. Without such dissenting opinions, there is very little incentive to make changes in proposed regulations.

One instance in which practitioners did influence drug regulatory affairs in this way is the recent controversy that arose over the legitimacy of drug combinations. The strong opinion of practitioners on the value of such medication in clinical practice played a very prominent role in making the Food and Drug Administration modify its rather restrictive policy.

Another way in which practitioners can effectively influence drug regulations is by working with drug manufacturers conducting clinical trials of chemotherapeutic agents. When a drug is rated other than effective it may only mean that there is a lack of controlled clinical evidence as to efficacy. Thus, physicians might offer to conduct clinical studies that could help keep a truly effective drug in the marketplace. The treatment of diseases such as diabetes and angina are areas where the practitioner can aid in clinical studies because patients suffering from these diseases are rarely found in the conventional hospital setting.

By working with ethically and scientifically sound study designs in his everyday practice, the practitioner could begin to play an important part in determining official ratings on drug efficacy.

Nongovernment physicians and scientists and the FDA should also improve their lines of communication to the public. The medical community must develop a voice every bit as loud as that of the consumerists, the press, and others who sometimes criticize without complete information. If not, much of wh the medical communi *and* federal regulators will often be represented simplistic and somewh misleading terms.

One illustration of t misuse of the media in tl regard is the recall of an coagulant drugs seve years ago. This FDA acti was given publicity by t press and television th went far beyond its pr able importance. The res was a very uncomfortal situation for the prac tioner who had patie taking these medicatio Since the practitioner a pharmacist had not b informed of the action the time it was publiciz in most states they w deluged with calls fr worried patients.

The practitioner can tempt to solve these pr lems of inadequate comm nication in several wa One would be the creat of a communications l in state pharmacy societ When drug regulation n is to be announced, the ciety could immediat distribute a message to ery pharmacist in the st The pharmacist, in t could notify the physici in his local community that he and the physic could be prepared to swer inquiries from tients. Another appro would be to use pro sional publications practitioner receives.

All of this leads bac my opening contention drug regulation is to b fective, timely, and rel to the realities of clin practice, a better metho communication and f back must be developed tween the nongovernm tal medical and scien communities and the r latory agency.

ue

Maker of Medicine

Henry W. Gadsden,
Chairman & Chief Executive Officer, Merck & Co., Inc.



In my opinion, it is the responsibility of all physicians and medical scientists to take whatever steps they think are desirable in a lawful regulation-making process that can have far-reaching impact on the practice of medicine. Yet many events in the recent past indicate that this is not happening. For example, it is apparent from drug efficacy studies that the NAS/NRC panels gave little consideration to the evidence that could have been provided by practicing physicians.

There are several current developments that should increase the concern of practicing physicians about drug regulatory affairs. One is the proliferation of malpractice claims and litigation. Another is the effort of government to establish the relative efficacy of drugs. This implies that if a physician prescribes a drug other than the "established" drug of choice, he may be accused of practicing something less than first-class medicine. It would come perilously close to federal direction of how medicine should be practiced.

In order to minimize this kind of arbitrary federal action, a way must be found to give practitioners both voice and representation in government affairs. Government must be caused to recognize the essentiality of seeking their views. One of the difficulties today, however, is that there is no way for concerned practitioners to participate in the early stages of decision-making processes. They usually don't hear about regulations until a proposal appears in the Federal Register, if then. By that time a lot of concrete has been poured, and a lot of boots are in the concrete.

Physicians in private practice, and particularly clinicians, should press for representation on the advisory committees of the Food and Drug Administration, joining with academic and teaching hospital physicians and scientists who are already serving. Though practitioners may not have access to all available information, the value of their clinical experience should be recognized. Clinicians, for example, rightly remind us that difficulty in *proving* precise effects does not necessarily mean a drug is ineffective.

Unless practitioners are more involved in drug regulations, it will be increasingly difficult for the pharmaceutical industry and scientists elsewhere to make optimal progress in drug development. The benefit/risk ratio must be re-emphasized, and as part of this it must be acknowledged that benefit can come from the judgments of medical science as a whole. Even this concept, unfortunately, is not always accepted in drug regulatory processes. For example, if current medical opinion holds that an excess of total lipids and cholesterol in the blood is probably predisposing to atherosclerosis, and if a drug is discovered which reduces total lipids and cholesterol, the drug ought to be accepted *prima facie* as a contribution to medical science . . . until someone disproves the theory. The sponsor should not have to prove the theory as well as to develop and test the drug.

I feel a major new effort must also be made to erase the feeling of mistrust of medicine and of medicines that seems to be growing in the public consciousness. Triggered primarily by strident announcements in Washington, people are reading and hearing confidence-shaking things almost continuously. Although challenge and awareness are essential to medical advancement, our long-term goal is constructively to build, not destroy. This means strengthening patient-physician relationships based on mutual confidence and trust. And in matters of health policy, it means working toward participatory rather than adversary proceedings—where everyone with an interest and a capacity to contribute has an opportunity to be heard . . . and, if that opportunity is not spontaneously afforded him, he may seek it.

Opinion & Dialogue

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Subcutaneous Mastectomy with Prosthesis-Implant for Lobular In Situ Breast Carcinoma

EVERETT SHOCKET, M.D., GILBERT B. SNYDER, M.D. AND JEROME BENSON, M.D.

The treatment of mammary lobular carcinoma in its in situ stage should prevent later invasive breast carcinoma from arising. Recognition of cancer at this stage is infrequent but there are now several hundred cases reported.[1,2]

Lobular carcinoma in situ of the breast is a serendipitous finding in biopsy specimens taken for presumably benign lesions. There are no known clinical or gross characteristics which permit preoperative or operative diagnosis of the lesion. Suspicion may be aroused by a unique, subtle mammographic pattern.[3]

The histologic features are subtle and must be differentiated from blunt duct adenosis, atypical terminal duct hyperplasia, fixation artifact and artifact created by tangential sectioning of the ducts. Frozen section diagnosis is rare as the appropriate area is unlikely to be selected for frozen sectioning and even if the frozen section happens to contain the usually unsuspected lesion, pathologists prefer to study paraffin sections before making a diagnosis of lobular carcinoma in situ.

Mastectomy has been the recommended treatment for diagnosed lobular carcinoma in situ.[4-9] We reason that a less mutilating operation can provide the same therapeutic protection and can be equally efficacious diagnostically. Removal of the breast is effective prophylaxis against later cancer. Semiserial sectioning of this excised specimen should reveal foci of invasive (as opposed to in situ) lobular carcinoma and, if found, more extensive surgery undertaken.

Our young patient was treated by a subcutaneous mastectomy with immediate silicone implant. The areola and nipple were excised as well with secondary transplant of labia minora tissue contemplated. The contralateral breast was biopsied. This definitive cosmetic approach has not been previously recommended, but does merit more general application. Zarem[10] undertook a staged subcutaneous mastectomy with silicone replacement for troublesome fibrocystic disease and adenosis. The final specimen did reveal two sepa-

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rate sites of in situ lobular carcinoma. He states (without advocating) that the original plan for delayed silicone implant was carried out.

Case Report

A 42-year-old divorced, medical laboratory technician presented with a serous discharge from the right nipple persisting for three months.

Bilateral fibrocystic nodules were palpable in the upper outer quadrants of both breasts. The left nipple was unremarkable. The right nipple surface was irregularly papillated, suggesting an atypical form of Paget's disease. Quadrant pressure of the breast failed to exude any material. At 6 o'clock, however, at the inferior areolar margin, there was a 0.5 cm. subcutaneous nodule. Mammograms were unremarkable.

On June 28, 1969 a wedge biopsy of the right nipple was performed with extension of the incision to include the nodule at 6 o'clock. On frozen section a papillomatous squamous cell hyperplasia of the nipple was reported with a separate fibroadenoma of unusual cellularity. The pathologist reserved final opinion pending permanent sections of the latter area.

Permanent sections showed lobular carcinoma in situ within a fibroadenoma (Fig. 1). This was confirmed by Dr. Frank Foote of Memorial Hospital and Allied Diseases, and by Dr. J. F. Kuzma of Marquette University School of Medicine.

On July 31, 1969 a subcutaneous mastectomy was carried out. The areola and nipple were also excised. A small Cronin silicone implant (Dow-Corning) was placed over the pectoralis major muscle to match the left breast. A biopsy of the upper outer quadrant of the left breast was performed.

Histological studies of the entire right breast specimen failed to reveal other foci of lobular carcinoma in situ or evidence of infiltrating carcinoma. The tissue from the left breast proved to be entirely benign.

Discussion

Foote and Stewart[1] first recognized the malignant potential of lobular carcinoma in situ. In 1967 they reported 42 patients followed from 1941 through 1952 without further treatment. The incidence of invasive carcinoma was 8% at five years, 15% at ten years and 35% at 20 years[4] and of these one third had disseminated—some fatally. Mastectomy proved 100% curative when no foci of invasive carcinoma was found upon serial sectioning of the mastecomy specimen. Multiple foci of in situ carcinoma is a common finding however.[5] In addition, the opposite breast is vulnerable to similar changes.[11] Random upper outer quadrant biopsies and/or mirror quadrant biopsies of the contralateral breast reveal changes (in situ usually; invasive rarely) in at least 10% [2, 5 (47%), 6 (10%), 7, 8 (40%), 14 (23%)].

Metastases have never been present in pure in situ carcinoma except in the uncommon instances where serial sectioning has missed a minute focus of invasive carcinoma.[12] Thus a decision for radical mastectomy hinges upon the finding of an invasive breast tumor after semiserial sectioning. Some have recommended radical mastectomy after the initial biopsy disclosed lobular carcinoma in situ simply to circumvent the need for an additional (i.e., third) operation should invasive carcinoma be found following subsequent histological studies of the simple mastectomy specimen.[13] Similar reasoning has led Benfield, Funderhut and Weiner[9] to argue for routine contralateral simple mastectomy rather than just contralateral quadrant biopsy.

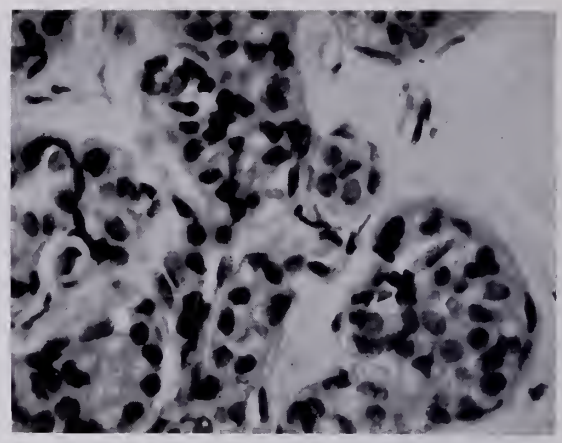


Fig. 1.—Lobular carcinoma in-situ x 500. H & E.

We propose that subcutaneous mastectomy can fulfill the two requirements needed in treating lobular carcinoma in situ. First, diagnostically, it removes the breast on the ipsilateral side as a total biopsy for semiserial sectioning to rule out invasive carcinoma. Secondly, therapeutically, by removing the breast, the evolution of invasive carcinoma is precluded. If truly invasive carcinoma is found on intensive histological study, the implant should be removed and a radical mastectomy completed. Finally, the subcutaneous mastectomy and implant should be considered a more feasible alternative for those who argue for simple mastectomy on the contralateral side rather than the traditional quadrant biopsy.[9] Though simple mastectomy, per se, may leave peripheral residue of breast tissue in the axilla, over the clavicle, over the sternum or overlying the rectus sheath, and indeed some radical mastectomy patients will be left with similar breast portions, the subsequent development of carcinoma is extraordinarily rare.[14,15]

Lambird and Shelley[16] have demonstrated the essential concentration of in situ lobular carcinoma to within 5 cm. of the nipple. Thus, simple mastectomy for near-areolar lobular carcinomas

in situ should include (as in our case) excision of the areola and nipple with later labia minora graft.

Whether the implant should be placed immediately or delayed is optional. The delayed technique gives the pathologist an opportunity to scrutinize the specimen and exclude any foci of invasive carcinoma. Placing the implant under the pectoralis major muscle[17] seems preferable as the muscle provides vascular support to the breast flap. This subpectoral position, also, facilitates future examination of the area with no risk of concealing any possible residue.

Conclusion

Lobular carcinoma in situ cannot be detected clinically or grossly. Suspicion may be aroused by a unique mammographic pattern.[3] Frozen section studies are usually not definitive, and only careful scrutiny of the paraffin sections permit the astute pathologist to make the diagnosis. Because it is associated with a high incidence of multiple foci, both in the same and in the opposite breast, and because if left untreated, the likelihood of true invasive carcinoma with fatality approaches 35% in 20 years, additional surgery is mandatory.

Traditional treatment has been mastectomy (simple or radical) with serial or semiserial sectioning of the ipsilateral breast tissue and a quadrant biopsy of the contralateral breast. We propose that the breast be removed by subcutaneous mastectomy and a prosthesis implanted. Quantitative tissue sectioning should be done to exclude invasive cancer. If true invasive carcinoma is found, the implant should be removed and a radical mastectomy carried out. The contralateral side is traditionally managed by quadrant biopsy. Alternatively a bilateral subcutaneous mastectomy with prosthesis-implant should be considered.

Summary

A 42-year-old divorcee with lobular carcinoma in situ of the right breast was treated by right simple subcutaneous mastectomy with removal of areola and nipple and with a silicone implant. A contralateral upper outer quadrant biopsy was also performed. No focus of invasive carcinoma was found in the removed breast tissue. The left breast biopsy proved to be entirely innocuous.

Lobular in situ carcinoma imposes a 35% risk of invasive carcinoma within 20 years. Mastectomy effectively prevents invasive carcinoma and is generally recommended. It is, however, deforming.

A plea is made for simple subcutaneous mastectomy and implant replacement in selected patients with lobular carcinoma in situ as a means both of ruling out occult foci of invasive carcinoma and preventing evolution of invasive carcinoma.

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May there never develop in me the notion that my education is complete but give me the strength and leisure and zeal continually to enlarge my knowledge.

Maimonides

Current Concepts in Cardiac Pacing

David D. Michie, Ph.D.

The concept of electrical stimulation of the heart is not new. In 1819 Aldini attempted to electrically stimulate the heart in decapitated criminals, and in 1862 Walshe recommended in his book, "Diseases of the Heart," galvanic stimulation for cardiac arrest. A few years later Duchenne claimed success in treating diphtheric patients with a slow heart rate. For a number of years significant clinical advancements in cardiac pacing were not made due to a lack of technological advancements in the development of implantable materials, batteries with extended life span and wires that would not develop fatigue fractures from constant beating of the heart. Finally in 1959, Elmqvist and Senning developed a fully implantable pacemaker. This feat was repeated the following year by Zoll et al, Kantrowitz and Chardack et al. These latter devices were equipped with power supplies that would last several years without replacement or recharging.[1]

In the past few years the number of indications for cardiac pacing have paralleled the development of more sophisticated pacing systems. In this paper the indications for cardiac pacing will be summarized as well as the different types of pacemakers and electrode systems that are currently available to satisfy these demands. Some highly specialized applications of cardiac pacing will also be discussed. It is beyond the scope of this presentation to discuss the various surgical techniques employed during implantation of the pacemakers or electrodes. The reader is referred to an excellent concise synopsis of this topic prepared by Yonkman, et al and illustrated by Netter.[2]

Indications for Cardiac Pacing

Electrical stimulation of the heart is carried out on a short-term basis or alternatively on a permanent or long-term basis. The indications for short and long-term pacing are summarized in Tables 1 and 2 respectively. In addition, there are highly specialized applications for cardiac pacing which include: (1) termination of supraventricular tachycardia with rapid pacing, (2) R wave coupled pacing to augment cardiac output or to slow heart rate, (3) paired pacing to slow heart rate, and (4) as a precautionary measure during coronary arteriography.

General Types of Nonimplantable or Short-Term Cardiac Pacemakers

These particular devices fall into either of two categories: (1) large line operated (110 volts, 60 cycle alternating current) instruments which are frequently incorporated into the same cabinet as a defibrillator and an oscilloscope for monitoring the electrocardiogram, and (2) smaller (about the size of a pack of cigarettes) battery powered units which are designed to be attached to the patient by a lightweight cloth harness. This latter device allows the patient to move about and, hence, facilitates evaluation of the efficiency of pacing under conditions of mild to moderate exercise stress. Both of these types of nonimplantable pacemakers are available for fixed rate or on demand operation (see subsequent discussion).

Table 1.—Indications for Short-Term Pacing.

1. Emergency measure in prolonged Stokes-Adams attack.
2. Acute myocardial infarction with complete heart block.
3. Slow heart rate due to a block.
4. Preparatory to long-term pacing.
5. During surgery in all patients with complete heart block and in others to cover the risk of cardiac asystole.
6. As a trial measure to see if cardiac output is improved by an increase in heart rate.
7. To suppress ectopic ventricular activity.
8. To provide graded stress for metabolic studies of the heart during cardiac catheterization.
9. Rapidly occurring Stokes-Adams attack to permit assessment of drug therapy.

Table 2.—Indications for Long-Term Pacing.

1. To prevent recurrent Stokes-Adams attacks in heart block.
2. Management of WPW syndrome complicated by paroxysmal supraventricular tachycardia.
3. Congenital heart block.
4. Suppression of ventricular arrhythmias.

Dr. Michie is Assistant Professor of Surgery and Director of Thoracic Surgery Research Laboratories, University of Miami School of Medicine, Miami.

General Types of Implantable or Long-Term Cardiac Pacemakers

Fixed Rate.—This particular application of cardiac pacing is designed for the patient who has complete heart block. Some units permit the rate and/or amplitude to be adjusted at the time of implantation, whereas the output of others is fixed in respect to rate and amplitude. Some units permit the physician to alter the rate after implantation, whereas another device permits the patient to select either one of two rates by the placement of a magnet over the implantation site of the pacemaker. This type of device was developed for younger and more active types of individuals.

Demand or Stand-by.—There are two types of demand pacemakers insofar as their mode of operation is concerned. The majority of the pacemakers in this category electronically detect spontaneous electrical activity from the ventricle and do not, therefore, produce an electrical stimulus unless the R-R interval exceeds a preset limit. In the second type of device, the normally occurring R wave triggers the pacemaker to fire with the stimulus being delivered during the absolute refractory period. If, however, the R-R interval exceeds the preset limit in time duration, the pacemaker functions as a fixed rate unit. A reported advantage of this latter type of demand pacemaker is that the EKG tracing reveals at any time whether or not the unit is functioning. An additional advantage is that the unit can be "triggered" at any desired rate by the application of small external stimuli. For a comprehensive review of the demand pacemakers the reader is referred to an article by Parsonnet, et al.[3] It has been stated that stand-by pacing precludes competitive rhythms and ordinarily avoids potential danger of the pacer pulses falling within the heart's vulnerable period.[4]

Atrial-Triggered Pacemakers.—This particular type of device senses the electrical activity associated with atrial depolarization (P wave) and, after an appropriate delay, stimulates the ventricles to contract. The atrial synchronous type of cardiac pacing was devised as the most physiological method for correcting complete or intermittent heart block.[5] A pacemaker which follows the atrial rate and supplies impulses to the ventricles after a suitable delay (P-R interval) has the obvious physiological advantage of increasing the intraventricular diastolic volume as a result of atrial systole. It has been demonstrated clinically that the stroke volume is greater when cardiac pacing is carried out utilizing the physiological placement of atrial systole.[6] On the other hand, it has been stated that the physiological advantages of atrial-triggered pacing, including augmentation of ventricular filling from atrial systole, are negligible in elderly patients with narrowed coronary arteries.[7] In summary, the reported advantages of atrial-synchronized pacing are: (1) for patients in whom the stroke volume does not adjust to allow adequate cardiac output to meet the demands for reasonable activity, (2) for patients in normal sinus rhythm and (3) for younger patients with disease confined to the conducting tissue.[8]

Cardiac Pacing Electrodes

Cardiac pacing electrodes may be either monopolar or bipolar in construction. Although several earlier reports claimed that bipolar electrodes were considerably superior to unipolar electrodes for long-term pacing and resulted in thresholds which stabilized sooner and at lower levels,[9,10] additional investigators have been unable to show any significant differences in the sensitivity of the heart to unipolar or bipolar stimulation.[11,12] In either case, the most widely accepted design is that of a helix constructed of elgiloy. It has been demonstrated that this configuration is less prone to develop fatigue fracture.

Pacing electrodes for long-term application may be sutured to the anterior surface of either the right or left ventricle (epicardial type). The most frequent surgical approach is a thoracotomy; however, in some instances a parasternal approach may be selected. Alternatively, the cephalic vein is exposed under local anesthesia and the catheter tip electrodes are advanced under fluoroscopic control via the transvenous route until they are wedged in the trabeculae of the right ventricle (endocardial type). The pacemaker per se is implanted subcutaneously regardless of whether epicardial or endocardial electrodes are used.

In most instances, the transvenous route to the placement of pacing electrodes is selected. The morbidity from this procedure is considerably reduced and less time is usually required for the procedure. This approach cannot be used in children because as they grow the electrode becomes too short. Epicardial electrodes are also implanted after there has been a break in the continuity of a previously placed endocardial electrode. The parasternal approach is selected when the need for epicardial electrodes arises and the patient is

either too ill or elderly to undergo a thoracotomy and general anesthesia.

Special Applications of Cardiac Pacing

Concept of Paired Pacing.—The spacing between paired pulses as well as the time between the paired pulse sets are variable. Paired stimulation has two independent effects: (1) the effect on heart rate and (2) a potentiation effect on ventricular contraction. If the delay between the two stimuli is correct, the heart rate can be slowed below its spontaneous rhythm by paired pacing of the ventricle. Thus, many arrhythmias (such as sinus tachycardia, ventricular tachycardia, atrial fibrillation) can be controlled. The affected ventricular contraction is augmented during paired stimulation of the ventricles as compared to ventricular contraction during single pacing. The Braunwald's have clearly demonstrated that this effect is related to the well-known postextrasystolic potentiation and is independent of the stimulating rate.[13,14]

Concept of R-Wave Coupled Pacing.—When a single electrical stimulus is applied at the correct interval following the R-wave of a spontaneous ventricular contraction, electrical depolarization will occur without mechanical contraction. This technique has been referred to as "coupled pacing."[14,15] The next result of coupled pacing is prolongation of the refractory period of the ventricle so that the next atrial impulse arrives during the refractory period, and thus does not give rise to a ventricular contraction. Hence, there is an immediate halving of the ventricular rate as coupled pacing becomes effective.[8]

Summary

Temporary cardiac pacing may be used to combat cardiac arrhythmias or as a diagnostic aid in evaluating cardiac function or drug therapy. Long-term, or permanent, pacing is most frequently used to prevent recurrent Stokes-Adams attacks in heart block and to aid in the management of WPW syndrome complicated by paroxysmal supraventicular tachycardia. The pacing electrodes may be either sutured directly to the epicardium or placed via a transvenous route directly in contact with the endocardium. The pacemaker itself is implanted subcutaneously thereby facilitating replacement in 18 to 36 months. It is frequently the surgeon's choice as to whether epicardial or endocardial pacing electrodes are used. The decreased morbidity, operating time and incidence of complication associated with the transvenous approach account for the widespread acceptance of this procedure except in specialized situations.

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Medical care problems have become political issues, because the more an issue rests upon an economic basis, the more political it becomes. The way to prevent the development of political medicine is to make it unnecessary.—Chester Scott Keefer, M.D., 1963.

Resection of Fibromyosarcoma of Pulmonary Valve

Report of Case

Sibu P. Saha, M.D., Theodore L. Batchelder, M.D. and Gordon H. Ira Jr., M.D.

Cardiac neoplasms are of special interest. They are comparatively rare, respond to effective surgical treatment, but prospects of a diagnosis are dismal. As a rule they are found accidentally at autopsy and create considerable confusion and controversy about their nature and origin. Little is known of their natural history and biological behavior. There are no reliable pathognomonic symptoms or signs. Often diagnosis is either impossible or a matter of chance.

The purpose of this report is to present a case of fibromyxosarcoma of the pulmonary valve. It is the fourth case reported in the literature and, as far as we have been able to ascertain, the first case treated by surgery.

Report of Case

A 39-year-old white male truck driver was admitted to St. Luke's Hospital, Jacksonville, on September 16, 1965 for symptoms of duodenal ulcer and an irritable colon. He also had a history of slowly increasing shortness of breath and easy fatigability. Physical findings were not remarkable with exception of a grade III murmur in the pulmonic area. Upper GI series showed a slightly widened esophageal hiatus, cascade stomach and mild deformity of the duodenal bulb. Chest x-ray revealed a coin lesion in the apical posterior segment of the left upper lobe in association with increased pulmonary vascularity. Planogram did not show calcification within the mass.

A left thoracotomy and wedge resection of the lesion was performed on September 24. No other lesions were present; however, the amplitude of pulsation in the pulmonary artery was very markedly increased and a thrill was present approximately over the left pulmonary artery. The lesion measured 1.5 cm. in diameter and the Armed Forces Institute of Pathology coded it as "?Vascular Leiomyosarcoma of Lung, ?Metastatic Malignant Schwannoma."

The postoperative course was completely uneventful and he was followed in the outpatient clinic. He was hospitalized again from November 3 through November 18 with chills, fever and pleuritic right chest pain, thought to be due to viral pneumonitis. Cardiac findings remained unchanged.

On December 9 at admission to Baptist Memorial Hospital, Jacksonville, the precordial grade III rough, ejection systolic murmur was more prominent over the second and third left intercostal space, radiating to the base of the shoulder and neck. P2 was greater than A2, fixed and widely split. A systolic thrill was present over the left intercostal space. A loud fourth heart sound was also noted over the right ventricle. The electrocardiogram detected a right bundle branch block. Clinically it was thought to be an atrial septal defect with pulmonary hypertension.

On December 15 a midline sternotomy was performed under general anesthesia with the patient on cardiopulmonary bypass. A large myxomatous mass (Fig. 1) was attached to the right leaflet of the pulmonary valve extending peripherally into the segmental pulmonary branches. It was possible to remove the tumor from the upper lobe arteries bilaterally and partially from the lower lobe arteries. The Armed Forces Institute of Pathology reported it as "Primary Fibromyxosarcoma of the Valve" (Fig. 2).

Except for a mild urinary tract infection, the patient's postoperative course was uneventful. A follow-up arteriogram (Fig. 3) from the femoral vein showed the upper lobe branches and left lingula, middle lobe arteries on the left and right all open. Lower lobe arteries were partially obstructed bilaterally. He was discharged December 31 and followed closely due to shortness of breath on exertion.

On March 15, 1966, x-ray of the chest showed multiple metastasis in the lungs (Fig. 4). He was seen again on April 4 with chief complaint of severe respiratory distress. Hypernea and cyanosis of the nail beds were noted. The blood pressure was 162/96 and pulse rate 110. The left pulmonary base was dull on percussion. A right ventricular gallop rhythm with grade III systolic murmur could be heard over the pulmonary valve area. The liver was moderately enlarged and 2+ ankle edema was present bilaterally.

Results of routine laboratory procedures were within normal limits. Chest x-ray revealed gross cardiomegaly and a huge left pleural effusion and two large metastases in the right lung. A thoracentesis produced about 2000 ml. of blood-stained fluid. On April 8 he died a few minutes after an emergency tracheostomy failed to im-

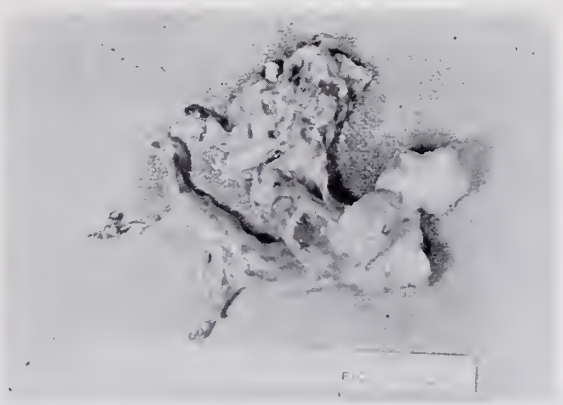


Fig. 1.—Naked eye view of the large myxomatous mass found attached to the right leaflet of the pulmonary valve.



Fig. 2.—"It is the consensus of opinion that the tumor represents a primary myxosarcoma of the valve. Sections of the lesion show sheets of mildly pleomorphic cells separated by dense collagenous tissue. In some areas the cells have abundant vacuolated cytoplasm while in others there is a marked paucity of the cytoplasm. Occasionally clusters of cells form a pseudoglandular appearance with the central portion consisting of highly vacuolated cytoplasm. The degree of mitotic activity is low."—Armed Forces Institute of Pathology.

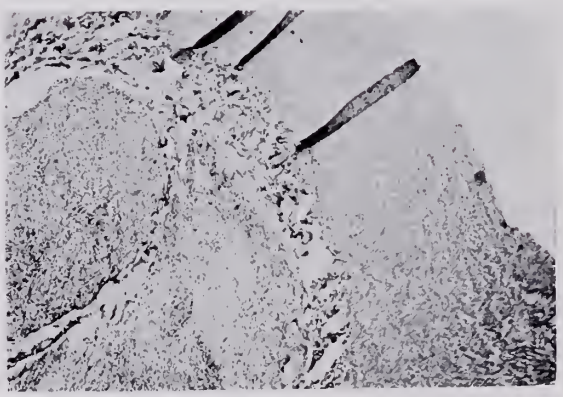


Fig. 3.—Tumor in the lung.

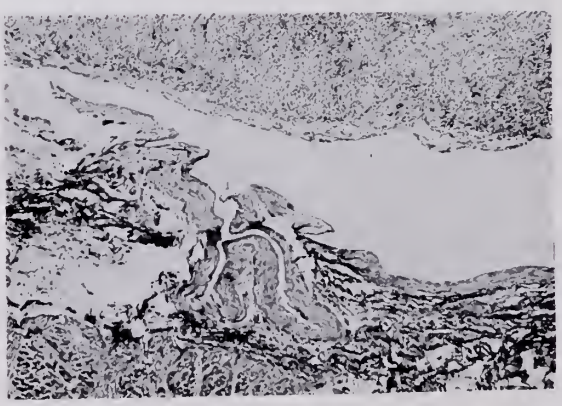


Fig. 4.—Aorta at pericardial reflection.



Fig. 5.—Region of pulmonary valve.



Fig. 6.—Pulmonary arteriogram, postoperative, left and right.

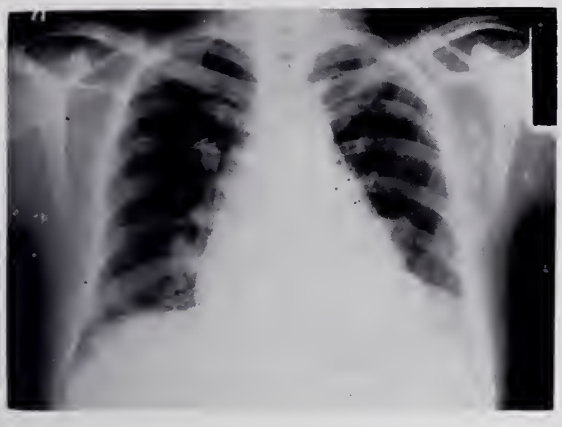


Fig. 7.—Roentgenographic examination of chest on March 15, 1966 showed multiple metastasis.

prove respiratory distress. The electrocardiogram recorded ventricular fibrillation which did not respond to defibrillatory treatment.

At autopsy pleural adhesions were present bilaterally and about 300 cc. of bloody fluid was noted in the left pleural cavity. The mediastinum was largely replaced by numerous tumor masses ranging in size from 1 to 6 or 7 cm. The surface was smooth, glistening, shiny and yellowish in color. On section, it was homogenous and greasy in appearance.

Microscopic examination revealed a malignant tumor with somewhat loose stroma with areas of myxomatous appearance, marked cellularity and numerous mitotic figures. Some of the cells were polygonal and some elongated with eosinophilic cytoplasm and prominent dark nuclei. The histologic pattern of the metastatic lesions was very similar to that of the original one. Tumor cells were identified in the lumen of some small blood vessels in the lungs and in one bronchus, but they were not attached to the walls. The tumor was seen growing into one mediastinal lymph node. Hyaline membrane and infarction were also detected in the lung.

Final Diagnosis

Fibromyxosarcoma of pulmonary valve with metastasis to the pericardium, lungs and mediastinum with left pleural effusion.

Discussion

Curtis[1] in 1871 apparently first described a tumor of a cardiac valve. In 1931 Yater[2] reviewed the literature and collected 25 fibromas of the heart valve, five of which were on the pulmonic valve but none were fibromyxosarcomas. Mandelstamn probably reported the first case of fibromyxosarcoma of the pulmonary valve in 1923, and in 1941 Haythorn[4] reported the second. Green et al[5] reported the third case in 1964 associated with syncope, intractable heart failure, polycythemia and thrombocytopenia.

Haythorn reported a second case of fibromyxosarcoma originating in the first portion of the pulmonary artery extending along the pulmonary tree and producing multiple metastases in the left lung and bronchi, and in the vessels of the right lung. Muller[6] described a case of "fibrosarcoma" of the left auricular wall with secondary nodules of the lungs and pleura. Fenster[7] reported a "malignant myxoma" of the left auricle with multiple metastases to the liver, lymph nodes, kidneys, adrenals and brain. We also found similar biologic behavior of this tumor.

Symptoms apparently due to valvular origin, stenosis or insufficiency are paradoxically associated with cardiac tumors of nonvalvular origin. Those tumors[8,9] which actually originate from valvular tissue are much less common, generally asymptomatic and have never been diagnosed during life.

Clinically this case presented with features suggestive of pulmonary hypertension and atrial septal defect.[10-13] The clinical features of primary pulmonary hypertension, obstruction of the pulmonary artery, as well as pulmonary venous and mitral valve obstruction may be similar, but differentiation is possible.

Steinberg et al[14] showed the significant role of angiocardiography in diagnosis of cardiac tumors, and Gerbode et al[15] emphasized the role of angiocardiography. Right heart catheterization and angiography would have made possible our preoperative diagnosis, but these could not be done due to the patients poor general condition.

The original coin lesion appeared to have metastasized from the tumor which may have been benign but ultimately underwent malignant degeneration and metastasized to the lung.

Summary

The first case of fibromyxosarcoma of the pulmonary valve treated surgically is reported. This is the fourth case chronicled to date. Findings were incidental in surgery. The patient recovered, led a useful life for a while, but ultimately died of metastasis.

Acknowledgment

We thank Drs. Whorton and Foraker, and Mrs. Betty Anderson, all of Jacksonville, for their help in preparing this article.

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Febrile Reactions to Procainamide

Peter O. Knight, M.D. and David P. Baumann, M.D.

Nine reports of fever and chills as a toxic reaction to procainamide have been documented in the general medical literature.[1-9] Hey et al[8] suggests that this reaction may be more common than heretofore realized and our observation of three cases in less than a year supports the belief. The cause of fever in the hospitalized cardiac patient may be difficult to determine but the effort is justified since high temperatures may produce deleterious effects on the cardiovascular system.

These case histories illustrate and emphasize the problems involved.

Report of Cases

Case 1.—A 56-year-old man was admitted to Tampa General Hospital at 1:50 a.m. on June 26, 1967 with chest pain and apprehension of several hours duration. An electrocardiogram was compatible with acute anterior myocardial infarction. Premature ventricular contractions and tachycardia responded to lidocaine, and procainamide 0.5 mg. every six hours maintained normal sinus rhythm. Typical serial elevations occurred in SGOT, CPK and HBD enzyme levels.

On July 12, following 16 uneventful days, the patient's temperature rose to 101.2 F. and chills were recorded. Over the next four days the temperature rose to a high of 106 F. Detailed physical examination, complete blood count, urinalysis, chest x-ray, blood cultures, and L.E. preparations revealed no abnormalities. Procainamide therapy was discontinued July 14 and the temperature gradually returned to normal. He was discharged one week later and has continued asymptomatic.

Case 2.—A 56-year-old white man was admitted to the coronary care unit at St. Joseph's Hospital on May 28, 1968 with severe crushing substernal chest pain. He appeared acutely ill, apprehensive and cyanotic. A few moist basilar rales were noted in both lungs and the heart tones were muffled. An electrocardiogram revealed evidence of an acute anterolateral infarction which was documented by serial elevations of SGOT, HBD and CPK. Gallop rhythm and increasing basilar rales necessitated institution of digoxin and diuretic therapy. Concomitant anticoagulation with warfarin was begun.

On May 31, due to multiple premature ventricular contractions, lidocaine 500 mg. in 500 cc. 5% dextrose in distilled water was administered at approximately 1 mg. per minute. Procainamide 250 mg. every six hours was begun. Intermittent furosemide was required for increasing pulmonary congestion. From May 31 to June 19 the hospital course was extremely stormy characterized by four episodes of ventricular fibrillation necessitating continuous lidocaine treatment supplemented with propranolol 10 mg. every six hours to suppress irritable ventricular foci. Daily temperature spikes of 101.2 F. to 101.6 F. were noted beginning June 15. Procainamide therapy was discontinued June 17 with prompt defervesence. It was restarted June 18 and prompt recurrence of temperature spikes to 102.6 F. were noted on June 19. A later test dose of 500 mg. every six hours for four doses resulted in fever and chills. The patient improved on digoxin, propranolol, quinidine and diuretic therapy and sinus rhythm was maintained for the remainder of the hospital stay.

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Some associated clues suggesting drug toxicity or idiosyncrasy as the cause of fever and chills in a patient receiving procainamide may be gleaned from previous case reports, notably a maculopapular rash, splenomegaly and eosinophilia.[5-8] None of these signs appeared in our cases.

The fever due to procainamide usually is remittent and the temperature may return to normal between spikes. An interval of approximately two weeks may be expected between initiation of therapy and development of symptoms. Subsequent treatment in the sensitized patient results in prompt reappearance of fever, usually within six to eight hours after the initial dose, which abates within 48 hours after discontinuance of the drug. The fever may be dose related; however, 250 mg. every six hours produced the reaction in several patients while others exhibited a similar response on 500 mg. every six hours. Patch and intradermal skin testing of several patients showed negative results.[3-5]

Despite the fever, the therapeutic effectiveness in suppressing arrhythmia was not altered in our patients.

Summary

Two cases illustrating typical febrile reactions to procainamide have been presented indicating the relatively common occurrence of this side effect. It appears consistent with a typical sensitivity reaction and is promptly reversible without apparent residual harmful effects upon withdrawal of the drug.

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The Hospital as a Therapeutic Instrument

"Milieu Therapy"

Samuel R. Warson, M.D.

Hospitals have the inherent potentiality of influencing the course of a patient's illness and recovery through the attitudes of its staff as well as their skills and physical resources. Certainly there is nothing new about the concept that pleasant surroundings and personnel who care about, as well as for, the patient are therapeutic or facilitate therapy.[1]

In psychiatric hospitals this potentiality has been systematically developed as a treatment modality and formulated in terms of hospital-patient relationships as "milieu therapy." This is a specific form of therapy based on a scientifically derived psychodynamic approach to human behavior as contrasted with the "moral therapy" of a century ago which was based on a philosophical humanistic approach.

Psychodynamics, or the study of motivation, made it possible to systematically take into consideration the influence of the environment on the structure and function of the personality system. Social psychology and social psychiatry are developments of this consideration as is the applied field of community psychiatry.

In the 1965 Strecher Memorial lecture, Zwerling based "milieu therapy" on: "The realization that a hospital is a community and that community life is a vital determinant of illness and recovery from illness." Zwerling concluded that milieu therapy works through conversion of the regressive inducing environment of "sickness" to one promoting healthy growth. The psychodynamics involved in this growth are similar to those described by Franz Alexander[2] in his conceptualization of a "corrective emotional experience," but in milieu therapy this experience is the product of a group process rather than individual transference.

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Recently, Visher[3] defined milieu therapy operationally as "a careful structuring of the social and physical environment of a psychiatric treatment program so that every interaction and activity is therapeutic for the patient." The kind of social structuring was researched long ago by psychologists and psychiatrists interested in group dynamics who found that a democratic rather than an authoritarian social structure facilitated the group process in our culture. The concept of a "therapeutic community" as the setting for milieu therapy was derived in this manner.

Procedure Described

As with all medical procedures, in milieu therapy there can be no real separation between diagnosis and therapy. Visher described the procedure as "an attempt to provide a learning situation in which causes for breakdown in relationships and communication can be discovered and corrected through experience in daily living." The data derived from individual relationships with members of the staff, from family, group and community sessions and from a variety of activities are pooled and shared by the staff and patients to make the hospital experience meaningful and useful as a human experience to all concerned.

If one subscribes to dynamic theory, milieu therapy can be definitive and probably is our best instrument for the treatment of character pathology. However, even when not definitive, milieu therapy can be of great help sociodynamically by presenting the patient with a less idiosyncratic definition of his situation. In a supportive group setting this frequently results in a modification of destructive behavior. Granted that behavior modification is not the final goal, such modification may make it possible to use more definitive treatment and is additionally valuable in the prevention of further complications.

Hospital's Role

The hospital as a therapeutic instrument is forged by health related professionals and technicians working together as a team within the framework of the medical model. The system on which this model is based has expanded in terms of knowledge and techniques beyond the scope of the physician and hence the use of a team of health related professionals. The final responsibility for how the instrument is used resides with the physician because the procedure is primarily a medical one and is carried out in a medical setting. However, except in emergency situations, the physician is also a member of the team and contributes to the group process that blends the contributions of its members into an organized therapeutic instrument, and this is a difficult role for many physicians to take.

From their origin as guest houses for pilgrims, hospitals evolved into a refuge for the sick and needy who had nowhere else to go. They had little to offer medically other than a humane approach until the clinical sciences developed. Hospitals then began to function as laboratories full of instruments concerned with the testing for, and curing of disease processes. The hospital itself as an instrument for the diagnosis and treatment of problems related to health is a more recent development and is based on a more holistic approach to illness as a life experience rather than a disease entity.

The modern hospital can now be a place where people go for help with problems related to their health. With our present state of knowledge this help can go beyond the necessary technical consideration of disease processes if the staff is organized to make the hospital a therapeutic instrument in itself. What psychiatry has learned about milieu therapy belongs to the medical model and is applicable wherever this model is used.[4]

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The Unbelievable Happens

We have a Republican Administration, so it could not happen. It would not be accepted by the A.M.A., so it could not come to pass. Yet now we have Phase II of the Nixon Economic Policy. We have a Price Commission to prevent price rises by industry, manufacturers, stores and shops, and individuals. The very first group who may not increase their incomes through price rises are the doctors. Doctors and institutions providing medical services must post price-lists for their patients. As with the supermarkets, they will no doubt be allowed to have "specials" and sales but, when the offer is over, prices must go back to the original level and not above. Shall we have "tonsil weeks" or "specials" on gallbladders or prostates? Patients will clearly be able to shop around, comparing the posted prices for a check-up or for a particular operation; and Internal Revenue Service agents will no doubt be faking illnesses to see that the prices are adhered to. Chiropractors, Christian Science practitioners—indeed all who provide medical or health services, health camps, rest homes, and so on—all are covered. So, of course, are the hospitals, though institutions are allowed a little more latitude: they can have a 6% rise while the doctors are limited to 2.5%, but the circumstances under which institutions can get their 6% rise are rigidly controlled and they will have to meet stiff conditions.

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Special Articles

Medical Traditions in Malaysia

Arlan L. Rosenbloom, M.D.

The importance of people's attitudes toward health and disease, their traditional health practices and willingness to adopt new practices are apparent to those involved in the delivery of health care. These forces of tradition are particularly interesting to study in Malaysia where a number of cultural streams come to bear on people's health practices. The cultural influences in the Malayan peninsula include the primitive through proto-Malay, Indian, Arab or Muslim, Chinese, and European.

Indigenous Malays make up half of the approximately 6 million population of Malaya. The Chinese comprise a third of the population and the Indians about ten per cent. In addition to these major groups there are thousands of Europeans, Eurasians and 50 to 100,000 Aborigine tribespeople.

Little is known of the earliest settlers of Malaya. An attractive simplification is to view the racial characteristics of the Chinese on one hand and the Indians on the other and see their blend in the people of southeast Asia. There is evidence suggesting that people drifted from the mainland of Asia through Malaya and the Indonesian archipelego, bringing primitive Asian culture and rice farming. For centuries these colonies spread and became well established and then, with the building of ships, came into the orbit of the civilization of India. For a thousand years thereafter, from the start of the Christian era, they were enriched by a blending of race and culture from the Indian subcontinent. Traders and artisans, architects, builders, princes and priests settled in the Malayan colonies and intermarried with the local people. They built temples and palaces of stone and brought to the Malays Sanskrit language and the principle of kingship by a semidivine ruler.

Despite this influence, the Hindu religion did not make significant in-roads on the animistic beliefs of the early settlers. But the great force of Islam, more readily adaptable to an animistic background, came by way of Sumatra and swept aside ancient beliefs, remolding the patterns of life of the Malays. This change began about 1300 A.D.



Figure 1

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Separate Cultural Groups and Their Ancient Traditions

Aborigines

The Aborigines probably represent the remnants of the earliest settlers of Malaya (Fig. 1). They vary from nomadic Negritos to proto-Malays. Several Aborigine languages are spoken, and at the fringes of the jungle transition to the Malay life style and language is going on constantly. The Aborigines are animists attributing occurrences to good or evil spirits and imparting spiritual significance to objects. The tribal medicine man is the medium between the land of the living and the spirit world and is able to enlist the assistance of the good spirits against the machinations of evil spirits who are the cause of illness, crop failures, floods, death, and other disasters. Contact with the spirits is generally made through ceremonial dances.

The Aborigines vary racially, but share a common distrust for the other races. Much of this distrust is justified by their traditional exploitation. This attitude, together with their isolation in deep jungle, has made the provision of medical services extremely difficult. An imaginative program involving the training of Aborigine medical assistants and the establishment of village-type hospitals near some of the larger hospitals in Malaya promises to provide sorely needed help to these people. Under these conditions they accept the medical services of the 20th century, though obviously interpreting the approach and effects in terms of their own beliefs.

Indian Influences

There are two great eras of Indian medicine, the Vedic, extending to 800 B.C., so-called because the teachings were contained in the holy Sanskrit books comprising the Vedas, and the Brahmanic, extending from 800 B.C. to 1000 A.D., so-called because it was based on the culture ideologically dominated by the Brahman caste, the caste of Hindu priests. The Brahmanic period includes the era when Indian colonization of southeast Asia was at its height, from 0 to 1000 A.D.

The practices described in the Vedas are common to all primitive systems and are based on concepts that are familiar in some degree to all societies; sin is the cause of disease, confession is the healing rite, and demons are to be fought with exorcism, spells and hymns. Many diseases are described in the Vedas with fevers predominating. This is not surprising since India is historically the most malarial country in the world and the world's breeding ground for cholera, plague, and smallpox.

The Vedic period was further characterized by a predilection for purifying treatment with water that has remained a part of Hindu religion, as well as Indian medicine practices and an unusual surgical skill in the use of prostheses.

During the Brahmanic period doctors belonged to a lower caste, below priests and warriors. Their assistants came from an even lower caste. Their medical training was acquired during an apprenticeship stressing the rational approach to diagnosis and treatment. Great attention was paid to the method of teaching and the proper balance between theory and practice, and medical and surgical training. Teaching models were used extensively. Introduction into the medical profession was in a solemn ceremony which included an oath not unlike that of Hippocrates. This is but one of many parallels between Brahmanic and Greek medicine.

The books of this era were probably based on Vedic material. Anatomy was fanciful and physiology was concerned with the equilibrium of the three body elements: air, phlegm and bile. That disturbance of this equilibrium produced disease was primarily a Buddhist concept. Hindu beliefs regarding transmigration of the soul added a further explanation of disease as being a punishment for a sin committed in a previous existence. This inevitable retribution, the Hindu Karma and the Buddhist development of the theme, are closely connected with attitudes toward animals and probably explains why veterinary and human medicine were not separated.

The Brahmanic physician made diagnoses using all five senses and thus recognized diabetes mellitus, calling it "honey urine," much earlier than his colleagues in the West. An elaborate and fantastic pulse lore was developed. Prognosis was sought in omens.

Disease classifications were quite elaborate. The Susruta lists 1,120 separate diseases including some very accurate observations such as the association of plague with mass death in rodents and the association of malaria with the presence of mosquitoes.

Treatment centered on hygiene and diet which remain important aspects of Hindu civilization. Cults grew up specializing in certain aspects of this approach such as yoga, which concentrates

on special breathing techniques. Three fundamental climates were recognized and change of climate was regarded as valuable therapy.

Indian pharmacopoeia was well developed with 760 vegetable drugs in addition to mineral and animal drugs being mentioned in the Susruta. The preoccupation was with aphrodesiacs, poisons and antidotes. It is interesting to note that, although Indian drugs became known to the West at the same time as Indian spices, it was the desire for the spices that led to the discovery of the New World after the land passage to India was blocked by the Islamic wave.

Hospitals were founded in India during a great religious revival engendered by the teachings of Buddha during the sixth century B.C., some 1,000 years before Christianity was to promote a similar movement in the West.

Indian medicine's greatest achievement was in the field of surgery. In the Susruta are described excision, incision, scarification, probing, extractions, suturing with the use of ants' heads as clamps, laparotomy, couching of cataracts, stone removal and most remarkably, plastic surgery. The last-named was predominantly otoplasty and rhinoplasty as a result of the frequent mutilation meted out by the traditional penal system. European origins of plastic surgery in medieval Italy are a direct offshoot of Indian surgery.

Smallpox inoculation was practiced by Brahmanic physicians in a manner quite descriptive of their style. Cotton pledgets soaked in matter from lesions were dried for one year. Each spring the physician would tour the area to perform inoculations. Those to be inoculated would abstain from milk and fish for one week before the procedure. Fifteen parallel incisions were made in the skin, the cotton was rubbed into these wounds and then they were sprinkled with water from the Ganges and incantations made.

This system of medicine, as well as the Chinese system which is discussed further on, is nonscientific and inseparable from religious influences. As such, it was destined to become static and dogmatic before it could evolve into a scientific system. Western medicine suffered the same fate through the Middle Ages, and though the main stream has emerged into the relative clarity of scientific objectivity, the persistence of cult practice in the most enlightened societies attests to the attraction of traditional concepts.

In Malaya the hygienic and dietary approach to treatment is a part of the cultural heritage of most Indians, including those who are now Christians and many Malays and Chinese as well. That the intestinal tract is a filthy tube that must be rinsed out to relieve ills should not be a strange concept to an American who has winced at the advertisements for high colonic irrigation so popular among California chiropractors.

Foods are generally classified as either heating or cooling. A "heaty" disease requires a diet of "cooling" foods and vice versa. Among the Indians food taboos tend to develop which can be especially harmful to pregnant and nursing mothers and infants. The devout Hindu mother will not cut her baby's hair or give the child a mixed diet until he is at least seven months of age, when on Deepavali, Thaipusam, or the Hindu New Year, the baby is taken to a temple or to the Batu Caves. There he is sprinkled with water, dried with incense smoke and the hair is cut by a priest. After the first three or four months of life, the dietary restrictions on these babies can result in significant failure to thrive.

Classical Indian medicaments, dished out of a vessel containing a goat's head or two, can be found in any market place and are quite popular (Fig. 2).

Chinese Influences

The ancient Chinese were an extremely literate society where even the gods were addressed by letter and governmental administration was handled by scholars. The compass was used as early as 1100 B.C. and silk, porcelain and printing were a part of Chinese civilization long before they were known in the West. Doctors, however, did not belong to the esteemed group of scholars.



Figure 2

The medical literature of the Chinese is extensive. Its beginnings are credited to three legendary emperors. The first was Fu Hsi, who in about 2900 B.C. invented the philosophy of the male and female principles in all nature, the Yang and Yin. Shen Nung, about 200 years later, was credited with the development of a drug lore and the description of acupuncture. Huang Ti, about a hundred years after Shen Nung, wrote the Neiching, the classic book of internal diseases. As in Indian medicine and on American television, anatomy and physiology are deductive and fanciful. Medical concepts were entirely dominated by a formalized and elaborate natural philosophy. At the same time there existed for the lower classes a supernaturalistic priest medicine based on primitive theories of soul abduction.

According to Chinese philosophy-science, the universe is divided into two principles: the Yang, or light and male, and the Yin, or dark and female, and five basic elements: wood, fire, earth, metal and water. These in turn are related to the five planets, the five directions, the five seasons, the five colors, the five sounds and the five organs of the human body. Music is the science of sciences and disease is the result of disharmony among the five fundamental organs. This disruption is in turn connected with interference from the planets, seasons, colors and sounds corresponding with each organ. An astronomical number of combinations is thus possible to explain any particular disease complex.

Diagnosis was based primarily on observation of the pulse and inspection of the tongue. Fifty-one types of pulse and 37 shades of tongue were described. Despite this remarkable specialization, sound observations were made. The itch mite was known and diabetes, smallpox, dysentery, measles and cholera were well described.

The pharmacopoeia of 1,800 drugs included many that were taken over by the West, such as ephedrin, chalmoogra oil, buffalgin, camphor, rhubarb, cod liver oil, iron, arsenic and mercury. To this day Chinese prescriptions are carefully compounded in intriguing stores with banks of tiny drawers. Important fossils have been discovered among the dragon bones used to fill these prescriptions.

Chinese aversion to the shedding of blood, combined with the belief that mutilation continues in life after death, completely thwarted the development of surgery despite a knowledge of anesthetics and the adoption of other Hindu practices.

Physical therapy was highly developed and included dry-cupping, massage and gymnastics. Chinese excellence in gymnastics persists to the present day.

Two therapeutic methods of ancient Chinese medicine deserve special mention because of their continuing importance. Acupuncture was based on the idea that the body contained many canal-like tubes, a natural idea for people whose agriculture depended on irrigation. Moxa is the burning of the patient's skin in the area of affliction with cones of hot dried herbs.

Legal medicine existed in China as early as the 13th century and fingerprints were used to identify criminals. There were apparently no concepts of public health and the descriptions of the filth of Chinese cities are legendary.

Though diplomatic relations between China and northern Malaya existed as early as the sixth century A.D., there was no significant cultural influence from China. During the past 100 years, however, Chinese immigration has made this cultural background a part of the Malayan scene. There seems to be a strong undercurrent of animism in the Chinese attitudes toward health and disease and this may reflect the humble mainland origins of many of the Malayan-Chinese. Many Chinese infants are seen with their heads shaved except for one lock left to drive away the devils. This head-shaving ceremony is carried out at the end of the first month of life. Some Chinese do not like to be complimented on the attractiveness of their children as this might attract the attention of evil spirits. A Chinese baby is dated from conception, rather than from birth, and is thus approximately one year old at birth. Should birth occur within a month of the Chinese New Year, another year is added.

Arab Tradition

Arab medicine represents the assimilation of Greek knowledge and its preservation for the West. Knowledge of the Greek legacy in medicine, as well as in other fields, came to the Arabs from Christians who had been driven out of the Byzantine Empire and who translated Greek authors into Semitic languages, first Syriac or Hebrew, and later Arabic. By the 10th century all Greek medical writing had been translated in Damascus, Cairo and Baghdad. By this time the Arabs were developing their own classic medical literature. Most famous of the Arab physicians was the Persian Avicenna, who lived from 980 to 1063.

His canon was for centuries the leading medical text in both East and West.

A second center of Arab medicine developed in Spain. The leaders in this center were Jews. Greek medical lore finally returned definitively to western culture when the Arab texts were translated into Latin. The first center where this occurred developed around Salerno near Arab Sicily and the first important medical university, Montpelier, in the south of France, bordered on Arab Spain.

Several characteristics of Arab medicine were similar to medieval western medicine, including the prevalence of astrology, the aversion to anatomic studies and the degradation of surgery. There were aspects, however, that made it clearly superior to western practice, and these were the knowledge of Greek literature, the extensive drug lore and the development of hospitals.

Malayan Medical Traditions

Until very recently the Bomoh, or Malay magician, held complete power where medical treatment of Malays was concerned. His medicine was built around superstition with a sprinkling of Hindu and Islamic practices handed down from father to son. The Bomoh can still be found in the markets of Malaya waving his testimonials, slamming his swords on the ground, and dramatically expounding his magic powers (Fig. 3). The nature of traditional Malay attitudes can be seen in the customs surrounding pregnancy and delivery.

In the old days and up to the present time in some areas, the pregnant woman went about in great fear. In her hair she wore an iron nail, which is rich in Semangat, or soul substance, to ward off blood-sucking vampires. She did not go out in the hot rain or yellow twilight, times when evil spirits abounded. An eclipse meant that her child would be born half black and half white. She feared that her husband might lame or blind a bird or split the mouth of a fish in his search for food, so that her child might be born with a club foot, blind, or with a cleft palate. Water was harmful and would increase her girth, so intake was restricted to dangerous levels of chronic dehydration. During the fasting month of Ramadan, the pregnant woman was expected to fast from dawn to dusk. Above all, she feared death in childbirth, which would make her become one of the vampires.

For the first child the ceremony called Melangyang Perut was carried out. The bedan, or Malay midwife, rocked the pregnant woman on seven sheets during the seventh month and threw each out the window. If they sailed cleanly through, this was a good omen. During the ninth month, the bedan did not leave the house of her patient. All doors were opened and knots untied so the delivery would not be impaired. With the onset of labor a special flower, Selusoh siti fatimah, was placed in water. As it absorbed the water, it opened. If it took less than three hours, labor would be short. If it took longer, it was felt to be a reflection of the sins of the mother against the father, especially suggesting adultery. Domestic difficulty at this crucial period was, therefore, not uncommon. When the cord was cut by the bedan, the spark of life was considered to pass into the infant. If the baby was a boy, the earlobe was pierced immediately to provide differentiation from the father. This was related to the belief in reincarnation with the fear that the vital spark might leave one or the other if their resemblance were great.

Special ceremonies surrounded the handling of the cord and placenta. It was washed, wrapped in a white cloth and buried with an iron nail under that part of the house where the delivery took place or under a seedling coconut palm in the yard. The mother stayed abed for 44 days following delivery with a continuous charcoal fire under her bed to help sweat out any poisons. This was an ideal circumstance for the development of thrombophlebitis, malnutrition and pneumonia. A seven-yard binder was worn around the abdomen, which was massaged with a hot brick wrapped in banana leaves. The baby was bathed in cold water and wrapped in a black blanket to ward off the evil spirits. It was not put to breast for four days but could get some water by spoon.



Figure 3

Custom continues to restrict what a mother can eat from the seventh month to the 44th postpartum day. Most of the valuable things in the Malayan diet are interdicted and during a time when she and the suckling infant need the best nutrition. Fruits, vegetables, coconut milk, fresh water fish and fish prepared with spices are forbidden. Special herb and root concoctions are taken. The overall result can be protein, vitamin and mineral deficiency with increased bleeding at delivery, anemia, beriberi, prolonged convalescence and poor quality breast milk. Traditional dietary restrictions exist for the Indian mother as well, especially regarding meat in the later months of pregnancy, and these can produce similar problems.

European Influences and Current Attitudes Toward Health

The Portuguese came to Malacca in 1411 as missionaries and traders. They intermarried and left some converts, but their cultural influence was not great or prolonged. The Dutch who replaced them had no interests other than commerce and their arrival in Malacca in 1641 began a century and a half of oppressive commercial monopoly.

British influence in Malaysia has been a significant social force in the 19th and 20th centuries. They originally established medical services as a means of meeting the needs of colonial personnel, but demand for these services spread to an ever-increasing number of inhabitants in contact with the colonials so that by evolution a socialized program of medical care evolved.

The modern spectrum of medical attitudes and customs of Malaya is a fascinating amalgam of western medicine, Chinese, Hindu and Malay practices, with none of these streams of tradition remaining totally uninfluenced by the others. Because of rising levels of education, improved transportation and communication and the obvious successes of western medical and surgical practices, modern medicine is in the greatest esteem and the influence of bomohs and traditional Chinese physicians is diminishing. The medical huckster, just as in America, is now forced to talk about vitamins and minerals along with powdered rhinoceros horn and royal jelly (Fig. 4).

Immunization is accepted by all races, although some undoubtedly interpret it as a form of modern acupuncture. Muslims do not allow autopsy to be performed and it can only be accomplished in cases of legal insistence.



Figure 4

Some bizarre customs persist such as the swallowing of newborn mice as a treatment for asthma and to get a good contraction of the uterus after delivery. Tiger meat is considered a good cure for arthritis. Chinese fracture treatment is still preferred by many. In this approach, the fracture site is pounded with special hammers until the bone is pulverized and the limb is then set for a month. Quack ideas are unscrupulously promoted just as they are in the United States. Vitamins are considered a source of power and a substitute for food. A certain brand of liqueur is promoted as a tonic, compounded like a Chinese prescription out of 33 secret herbs. It must be said it is no more expensive than Hadacol or Geritol and considerably tastier.

Our own experience tells us that there will always be those who are ready to turn to the magic potion, the healing faith and the simplistic pathophysiology.

The Chinese patients with fractures leave the hospitals in Malaya with fresh casts to seek traditional treatment and Malayan children with meningitis are taken from the wards to the bomoh before they have had antibiotics. Those who fully accept modern medicine and surgery must elevate scientific medicine to spiritual heights. A grateful Chinese patient, treated for tuberculosis, had a commemorative plaque made which translated roughly as: "You have established your reputation, your service, your deeds which are well known throughout the five continents. The memorial will be carried from generation to generation for a thousand autumns. It is good fortune that brings the American doctor thousands of miles to meet us. The work of all combines as ores in a furnace to produce the hard alloy of healing ser-

vice. As a result of these things, the southern heavens are filled with fruit and remain ever green. The angels are rejoicing with sweet voices in the palace of the emperor of the heavens. The three races—Chinese, Malay, American—love each other as one body. The spirit of this fusion of races will live forever in history."

To approach an understanding of attitudes toward health and disease in multiracial Malaysia has required an appreciation of 2,000 years of medical history. The lessons of this odyssey seem to be that there has always been a major role in society for a healer, regardless of his effectiveness, and that his theory and practice are bound to the prevailing philosophies. We may thus consider ourselves fortunate to be living in the scientific era. However, the modern physician ignores at his own peril the remainder of the lesson—that while the theory of practice is determined by the prevalent scientific concepts, the manner of practice is decided by the dominant political or religious philosophy of the larger society.

Dr. Rosenbloom, Department of Pediatrics, University of Florida College of Medicine, Gainesville 32601.

So you've been invited to give a speech . . .

Don't accept any speaking engagement until you've given the matter careful thought.

Find out first who the other speakers will be, particularly if you're on a panel; where the meeting will be held; size and kind of audience; the length of the talk desired; whether there will be a question and answer period.

With these facts, you will be able to determine whether you can give a talk which will be suitable to the audience's interest. And whether you are qualified. Do you still think you can give a good account of yourself?

Then—and only then—will you know whether to say yes or no to the invitation.

Whether you are talking to an audience of 5 or 5,000, the qualities that spell success are the same and they can be achieved through planning and practice.

As for the length of your talk, it's well to heed the clerical axiom, *"No souls are saved after twenty minutes."* Nor should you employ the tactics of old time orators who kept the audience awake only by the loudness of their voices. Neither loudness nor length is any test of excellence in a speech.

Fight the temptation to begin talking the second the program chairman introduces you. First, pause a few seconds after being introduced. It's best to skip a long introduction and to plunge into your subject. Many experienced speakers begin with a knowledgeable compliment to the audience, organization and place. If you're pleased to be with the group, it won't hurt to say so. Above all, don't begin with an unrelated joke.

Many a well-prepared speech has failed for lack of rehearsal. If you run through a speech several times you usually speak from cards or notes, to remind you of main points. And you won't run overtime. But rehearsal isn't just practice—it has to be intelligent practice. Intelligent, because the psychologists tell us practice doesn't necessarily make perfect, it only makes permanent.

Being easy in front of an audience comes from being well prepared and well rehearsed, and knowing you are both. Your desire to communicate should be strong enough to cause nervousness, but never paralyzing fear. In fact, nervousness can be downright helpful if it drives you to the important task of preparation.

While presenting your speech, be psychologically ready for anything. If you're a member of a panel, you may have to cut material because a preceding speaker deals with it in an ad lib.

An awkward finish has marred many an excellent speech. After uttering the last word, nod to your audience, smile, turn, and walk to your chair. It's that simple. And remember, it's not an act of discourtesy NOT to thank your audience. In fact, a "thank you" weakens your talk by seeming to apologize to an audience that should appreciate the message you've given them.

Reprinted from the Illinois Medical Journal, November 1971.

Editor's Note: To entice you to Hollywood next month for the 98th Annual Meeting of the Florida Medical Association, we solicited two articles for food lovers from experts in the area. To make your stay more pleasant at the meetings, reprints of this article and the one to follow next month will be available at the registartion desk in the Diplomat.

RX FOR PRANDIAL PLEASURES

Richard and Lenore Fleming

Just as no prescription is universally applicable to all patients, no recommendation for food would appeal to all palates. You might have your own favorites—if not, here's an abbreviated gastronomic pharmacopeia of the lower Gold Coast which you might find helpful in choosing a place to dine.

Hollywood

Diplomat Hotel: You don't have to leave the convention hotel to find good eating places—consult the hotel directory for a description of their offerings. Unfortunately, our favorite, the Celebrity Room closes for the season before our convention opens.

Top of the Home Restaurant: 1720 Harrison St. —949-3549. Nicely appointed room atop the Home Insurance Bldg. with excellent views of Hollywood area. Continental cuisine—excellent. Moderate—Expensive.

Moys: Young Circle—WA2-4272
Very popular Chinese Restaurant; all the favorite Chinese dishes. Moderate.

Fort Lauderdale

Down Under: 3000 East Oakland Blvd.—564-6984.
Attractive and unusual decor, located literally "down under a bridge" on the intercoastal waterway. Large variety of delicious food tastefully prepared and interestingly served. Moderate.

Le Dome of the Four Seasons: 333 Sunset Drive. —525-3303. Continental cuisine; excellent. Magnificent view worth visiting for this alone! Expensive.

Clipper Room at Yankee Clipper: 1140 Seabreeze Blvd. A1A. 524-5551. Excellent continental cuisine; intimate, charming. Moderate-Expensive.

Beni Hana of Tokyo-Japanese Steak House: 4343 Trade Winds Ave., Lauderdale-by-the-Sea; 566-1569. Our friends say this is one of the best eating places in the area. Moderate-Expensive.

Hallandale and Upper Miami Beach

Manero's Restaurant: 2600 East Beach Blvd. 923-1661. Steaks and Italian food; known for cheese salad. Very popular; usually overflowing. Moderate.

International Inn in the Hemispheres: 1970 Ocean Drive. 944-6345. You must try their Peking Imperial Duck—great! Moderate-Expensive.

Grist Mill: 19400 Collins Avenue. 947-2676. In the Sheraton Beach Resort Hotel on the ocean. And it is a grist mill—an attractive replica, that is! American cuisine; large menu. Everybody seems to enjoy this one. Moderate.

Christine Lee's Gas Light Restaurant: 17901 Collins Avenue. 945-9075. Excellent Chinese food *and* American too, especially the steak—none better. Moderate.

Bal Harbour—Bay Harbor

De Continental: 1045 - 95th Street. 865-8224. French-Italian dishes. Elegant setting. Expensive.

Post & Paddock: 9650 E. Bay Harbor Drive, Bay Harbor Island. 866-8706. American cuisine; steaks, seafood. Old standby. Small version of 21 Club in New York. Moderate-Expensive.

Gaucho Room, Americana Hotel: You know this one! Great steaks.

Miami Beach

Bernard's: 5401 Collins Avenue, in the Carriage House Apt. Hotel. 864-4804. Small, plush, quiet. Continental cuisine. Menu limited but excellent and especially prepared by Bernard. Expensive.

Embers: 245 - 22nd Street. 538-4345. Famous for hickory cooked steaks, ribs and chops as well as pheasant and other fowl. Always popular. Moderate-Expensive.

Gatti's: 1427 West Avenue. 637-1717. One of the oldest and best restaurants on Miami Beach. Italian with continental flair. Veal dishes outstanding. Joe Gatti will charm you. Expensive. May be closed; be sure to call.

Joe's Stone Crabs: 227 Biscayne Street (near the southern tip of Miami Beach). 637-0365. A landmark. No one wants to miss this one—marvelous stone crabs (cold of course), hot drawn butter, hash-brown potatoes and the secret formula coleslaw washed down with Heinekens beer. No reservations and you will wait (pleasantly, in the bar!) unless you come before 6:30 or after 8:45. Moderate-Expensive.

Le Parisien: 474 Arthur Godfrey Road (41st St.). 534-2770. Small, chick; French cuisine of highest quality. Try Duck a L'Orange if you like duck. Expensive.

Old Forge: 432 Arthur Godfrey Road. 534-4536. Interesting decor. Excellent steaks and chops. Usually crowded but good service. Nude art in the bar attractive—the loud music, not. Open late. Moderate-Expensive.

Omar's Tent: 534 Arthur Godfrey Road. 532-8422. Small and unpretentious place with variety of excellent Syrian-Lebanese foods. The Kibbi Tartare and Tabooley salad are excellent side dishes but can be a meal in itself. Desserts are mouth-watering. The Turkish coffee is "mud" but we like it. Inexpensive-Moderate.

79th Street Causeway—Miami Beach

Nick & Arthur's: 1601 - 79th St. Causeway. 866-9759. Excellent food; American cuisine; steaks, stone crabs. Large and somewhat bustling. Good service. Moderate.

Mike Gordon's: 79th St. Causeway on the Bay at Miami side. 759-6825. Old reliable seafood place; Red Snapper a specialty. Moderate.

North Miami—Off Broad Causeway

Cattleman: 1800 N.E. 124 Street, Miami. 891-1600. Plush 1890's decor with 5 or 6 rooms decorated differently—be sure to see them all. Good food—American. Complimentary wine, liqueurs and cigars with steaks (which are great). What more can one ask? Moderate.

Casa Santina: 10999 Biscayne Blvd., Miami. 754-2431. Real Italian—none better. Very popular. Moderate-Expensive.

Miami

Cafe Les Ambassadeurs: In the Sheraton Four Ambassadors: 801 S. Bayshore Drive. 377-1966. French cuisine. Elegant dining in a plush setting. Strolling violins; steaks flamed at table. Steak au Poivre great if your stomach mucosa is in reasonably good condition. Crepe Suzettes and Cafe Don Juan prepared by the Maitre d' with a flourish. Moderate-Expensive.

Piccadilly Hearth Restaurant: 35 N.E. 40th Street. 751-1818. Located in the midst of Decorator's Row. (The ladies in particular will enjoy strolling thru this unusual street). Small, charming, elegant English Pub decor. Delicious food with daily specialties; equally good for lunch. Moderate.

Vizcaya Restaurant: (No connection with Vizcaya Art Museum) 2436 S.W. 8th Street. 642-9022. Spanish-Basque cuisine. Large selection; delicious; crowded and lively. Flamboyant decor. Moderate.

Centro Vasco: 2235 S. W. 8th Street. 643-9606. Like the Vizcaya; Spanish-Basque. Seafood, steak madrilene a specialty. Moderate. Can't go wrong with either of these.

Les Violins, Inc: 1751 Biscayne Blvd. 371-8668. Operated by group of Cuban expatriates, all of whom work as waiters, cooks, managers, etc. The waiters double as entertainers (they're good too!) and some entertainment goes on almost continuously. Continental cuisine with a heavy lacing of "Cubana." The atmosphere is worth coming for even if the food were mediocre! The Latinos come late but you can dine at your usual hour. Moderate.

Flamenco Supper Club: 991 N.E. 79th Street. 751-8631. Same as above with same operators.

Miami Springs

Japanese Steak House: 500 Deer Run. 871-6000. Pretty girls in kimonos prepare your beautiful steak Japanese style where you sit; either at a floor table or conventional table. A tasty treat and delightful experience. The homeopathic servings of Sake are just right. One price: $8.50.

King Arthur's Court: 500 Deer Run. 871-6000. Huge, high-ceilinged room with ornate Medieval decor attractively done. You guessed it —Beef is the favorite and the prime ribs are the best. No reservations—usually a wait, especially on week-ends. Moderate-Expensive.

Key Biscayne

Jamaica Inn Restaurant: 320 Crandon Blvd. 361-5481. Spacious, with enclosed tropical garden. American cuisine; Roast Beef a specialty; frog legs, steak, etc. The President's favorite restaurant. Moderate-Expensive.

The English Pub: Next door to Jamaica Inn. 361-5481. Copy of an English Pub and most attractive. Informal. Be sure to look at the various rooms. Menu similar to above. Moderate.

Be sure to call for reservations—most places require it (two or three exceptions). Although we have checked most of them as to closing dates for the season, this sometimes changes and you might save a trip by making a call. Get a map and directions before setting out—it will save you time!

Good eating!

Dr. and Mrs. Fleming, 1688 Meridian Avenue, Miami Beach 33139.

Florida Medical

Association

98th Annual Meeting

May 3-7, 1972

Diplomat Hotel

Hollywood-by-the-Sea

See preliminary program page 58

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IMPORTANT NOTE: *In vitro* sulfonamide sensitivity tests are not always reliable. The test must be carefully coordinated with bacteriologic and clinical response. When the patient is already taking sulfonamides, follow-up cultures should have aminobenzoic acid added to the culture media. Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of antibacterial agents including the sulfonamides, especially in the treatment of chronic and recurrent urinary tract infections.

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Contraindications: Hypersensitivity to sulfonamides, infants less than 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis), pregnancy at term, and during the nursing period.

Warnings: Safety of sulfonamides in *pregnancy* has not been established. Sulfonamides will not eradicate group A streptococci. Deaths associated with sulfonamide administration have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts and urinalyses with careful microscopic examination should be performed frequently during sulfonamide therapy.

Precautions: Use with caution when impaired renal or hepatic function, severe allergy or bronchial asthma is present. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis (frequently a dose-related reaction) may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia, methemoglobinemia. *Allergic reactions:* Erythema multiforme (Stevens-Johnson syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia, allergic myocarditis. *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis, stomatitis. *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L.E. phenomenon have occurred with sulfonamide therapy. Sulfonamides bear certain chemical similarities to some goitrogens, diuretics and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents.

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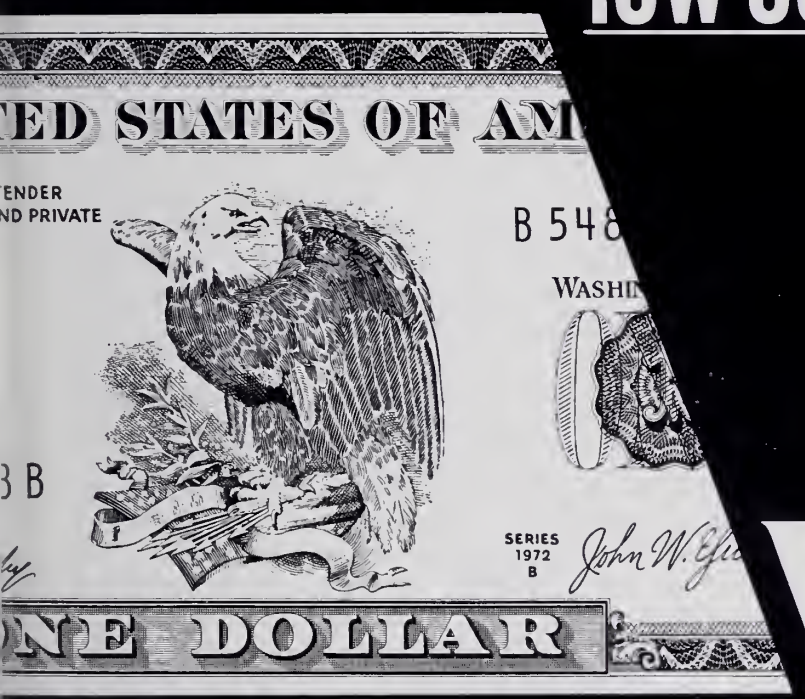
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FMA Personalties at 14th Annual Meeting of County Medical Society Presidents and Secretaries, Orlando, in January.



(Top, left to right) Dr. Floyd K. Hurt, FMA President welcomes Congressman Paul G. Rogers to the rostrum; Dr. Joseph C. VonThron, FLAMPAC President; Dr. Ernest B. Howard, Executive Vice President, AMA; Dr. Francis T. Holland, Member, Subcommittee to Committee on State Legislation; Dr. John H. Parker Jr., President, Taylor County Medical Society; Dr. Marvin G. Burdette, President, Polk County Medical Association; Dr. James W. Clower Jr., Member of Council on Specialty Medicine; Dr. George S. Palmer, Executive Director, Florida State Board of Medical Examiners; Dr. E. Charlton Prather, Chief, Bureau of Preventable Diseases, Division of Health; Dr. John M. Malone, President, Clay County Medical Society; Dr. Jere W. Annis, Member, AMA Board of Trustees; Dr. Francis C. Coleman, Member, Commission on Health Industry Costs; Dr. Wilson T. Sowder, Director, Division of Health; Mrs. Wesley S. Nock, President, Woman's Auxiliary; Mrs. Arnold J. Spanjers, Immediate Past President, Woman's Auxiliary; Dr. Edward G. Haskell, FLAMPAC President-Elect; Dr. Irving M. Essrig, President, Hillsborough County Medical Association; Dr. John J. Cheleden, Vice Chairman, Judicial Council; Dr. William H. Hubbard, Chairman, Committee on Continuing Medical Education; Dr. Vincent P. Corso, Chairman, Judicial Council; Mr. W. Harold Parham, FMA Executive Vice President; Dr. Ray E. Murphy Jr., Vice President, FMA Board of Governors, and Dr. Joseph H. Davis, President, Dade County Medical Association. (These candid shots courtesy of Dr. John W. Glotfelty, Lakeland).

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Editorials

We, the AMA

Chapter II

The patient was moribund, the doctor said, and urged surgery but the House of Delegates, unconvinced, suggested "take two aspirin and call me in the morning." So began an article in a recent medical journal by a former AMA staff member, reporting on Dr. Hall's address at the AMA's Twenty-Fifth Clinical Convention in New Orleans last December. Troubled and disturbed after five months as its president, he appeared more convinced than ever of a growing disenchantment with the AMA among U.S. physicians and a corresponding weakening of its ability to speak as the voice of American Medicine.

Needed, he said is a review of the association's basic organizational structure and constitution. Expressing concern about the number of physicians dropping their membership, he believed that by instituting changes in the organizational structure and the services provided, more physicians would be eager and proud to join the AMA and actively participate in its programs. The basic objective of the AMA, he said, is to promote the science and art of medicine and the betterment of public health, but in recent years more and more emphasis has been placed on politics and legislation and relatively less and less on scientific and medical education.

In addition to calling a national meeting of officers and representatives of specialty societies, Dr. Hall believed that every means should be explored to find ways in which the AMA and specialty societies could work together. He expressed interest in the House of Delegates becoming bicameral, one for state medical associations and the other for specialty societies but quoted figures showing all specialties represented in the House on a fairly equitable basis. He questioned whether the AMA is providing the practicing physician with the help and services he needs today as the practice of medicine becomes more complicated and more entwined in red tape and federal legislation. Dr. Hall also sensed a feeling of insecurity and lowered morale among staff members. In conclusion, he requested the association establish meaningful priorities, live within its means and bring about a unity of purpose.

After Dr. Hall's address, the House of Delegates took a middle stand by passing a resolution that the subject of constitutional changes, organizational structures and delineation of committee responsibility be referred to the Council on Long Range Planning and Development; and, that open hearings for members be conducted in San Francisco in June and in Cincinnati in November of this year.

The next day a group of thoughtful delegates of varying philosophies and backgrounds, invited to dinner by another drug journal, were divided in criticism of Dr. Hall for raking the organization over the coals in public. In the candid discussion that followed, one delegate, defending the AMA, said, "We are being blamed for deficiencies that may not be entirely our fault, but yet they are there and we are expected to do something about it." Another said, "Whether we like it or not we are responsible to see that maximum efforts are made to correct the unavailability of medical care." The Speaker of the House, also present, advocated if there is real honest to goodness worth in the AMA it is because it really means what it says when it is trying to line up the medical profession for the good of the people. Rather than charging students $20 for getting into the AMA and sending them the Journal, another said, the AMA should give them what they need and want to know, such as, what it costs to run an office;

why you do not split fees; why do doctors not give away more time to the poor, and why do they not serve all the people who are screaming and dying. The students, another opined, want an organization that will help them discharge the broad social responsibilities they cannot cope with as individuals, and the AMA should be such an organization that the kids will break down the walls to get into. Whether, however, the student problem can be solved by increasing permissiveness or increasing discipline is debatable.

Still another delegate said the AMA should be concerned about the distribution of medical care in regards to physician placement, and, being a service organization, some kind of practice management mechanism should be outlined to aid practitioners who wish to continue in private solo practice.

In defense of the status quo, it should be pointed out that Dr. Hall's proposal to restructure the AMA's basic organization was made without giving any specific reasons for it or methods to accomplish it. Besides being very unwieldly, a bicameral house would require changing the basic nature of the AMA from its present status of a confederacy of state organizations. All other criticisms made by Dr. Hall were extremely general without positive constructive suggestions. His opinion of lowered staff morale was not shared by others. Finally, the organizational structure and modus operandi of the AMA was, to a large degree, shaped and determined by the Board of Trustees on which Dr. Hall served for nine years prior to his becoming president.

That resolution by the House of Delegates concluded with, "progress reports be provided and a summary on its recommendations and findings be presented at the annual meeting in June 1973 in New York."

Going even beyond the changes suggested by Dr. Hall, the Council on Long Range Planning and Development, in examining the AMA's present and future, is holding hearings in all parts of the country, hoping that many will appear to identify a specific problem and propose a specific solution. These scheduled open hearings could conceivably pave the way for a rejuvenation of and re-interest in the AMA, if only enough rank and file members around the country turn out and speak up. Here is an opportunity for all to air our chief complaints, to get involved in the programming of our own affairs, to direct and control our own destiny and to make the AMA an organization that truly represents the American physician.

After Dr. Hall's address in New Orleans, Dr. Ed Annis, an AMA past president, said, "the less people know about the AMA the more critical they are." So, why not inform others about its virtues, then, by working together and trying new ways of rallying more physicians to its cause, we can make a good organization even better.

C.M.C.

Editor's Note: At the Editor's Breakfast in Orlando, during the annual FMA meeting of County Society Presidents and Secretaries, each participant was asked to pen a reply to the following question: IN YOUR OPINION WHAT IS THE MOST IMPORTANT FUNCTION OR FUNCTIONS OF THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION? Below are six functions that we thought worthy of reprinting:

(1) To keep the physicians of the state informed about Association activities.
(2) To provide a forum for scientific excellence.
(3) To act as a mechanism for discussing important, and at times, controversial topics.
(4) To emphasize "Florida Medicine" and to show others the excellence of the many superior physicians and medical organizations in the state—including special issues related to certain topics.
(5) To emphasize in certain issues the uniqueness of Florida's past, such as the superb articles on Seminole Indian Medicine.
(6) To involve, as early as possible, the medical student and resident in the activities of organized medicine.

G. L. Schiebler, M.D.
Gainesville

Shall We Continue Using Hexachlorophene?

Hexachlorophene, the most widely used chlorinated bis-phenol, became a hotly debated substance following publication of the December 1971 FDA Drug Bulletin. Safety of this antiseptic was questioned for total body bathing of newborn infants; in fact, it was recommended that this be stopped.[1] Several hospitals immediately extrapolated this recommendation to the point that all applications of hexachlorophene are to be discontinued. To make matters worse some soap manufacturers are sending letters to physicians and public alike emphasizing that their proprietory products never contained hexachlorophene or its addition has been discontinued. Is this an overreaction?

Antiseptics have several bona fide preventive indications; however, their therapeutic application has greatly declined. The majority of antiseptic usage is unnecessary but sophisticated advertising campaigns kindle our "Bug Fear" and indoctrinate the layman about odor-producing, itch-producing bacteria living on the skin and in orifices waiting to cause infected lesions. The implied remedies are germicidal solutions, soaps, mouth washes, feminine hygiene sprays and even "private" deodorants for men. In vitro determinations of germicidal activities, which are inadequate even under the best circumstances, are given as proof of their effectiveness.

Hexachlorophene, a halogenated phenol more bactericidal than phenol itself, combines with cornified cells and inhibits bacterial growth. Because of low solubility in water, hexachlorophene in different formulations may show variable antibacterial activity but mainly against gram-positive bacteria.[2,3] This effect is obtained after several applications. The reduction in bacterial flora observed immediately after a single scrub with hexachlorophene soap is no greater than that obtained with nonmedicated soap.[4] With repeated use hexachlorophene accumulates on the skin, reaching maximal concentration in two to four days. Removal of the film and regrowth of normal flora begin promptly when a soap not containing hexachlorophene is substituted.

Hexachlorophene is less irritating to tissue than phenol but concentrations of 10% or more can produce a primary irritant dermatitis in sensitive areas such as the skin of infants or scrotal area of adults.[5] Most dermatologists agree that the substance is too drying, giving the skin a harsh, chapped feeling.

That hexachlorophene is absorbed through the intact skin of newborn infants and the denuded areas of burn patients is well accepted.[6,7] Krimbrough reported that accidental ingestion of hexachlorophene preparations resulted in severe gastrointestinal symptoms with abdominal cramps, diarrhea, dehydration and even shock.[8] Once past the gastrointestinal tract, the principal target is the central nervous system where it produces ocular abnormalities (loss of light reflex, alternating dilatation and contraction of pupils, papillary edema, nystagmus) convulsions and in animals weakness in the hindlegs. Larson's studies of causation of burn encephalopathy (confusional state, stupor, coma, muscle twitching, choreo-athetosis, convulsions, cerebral defects and cerebral edema in burned patients) suggested hexachlorophene treatment as a possible etiologic agent.[7] High doses of hexachlorophene administered to rats produced spinal and brain lesions limited to the white matter consisting of cystic spaces that appeared empty. The gray matter was not affected.[9] Similar findings have been reported in newborn monkeys washed daily with 3% hexachlorophene for 90 days.[1]

These studies question the safety of using hexachlorophene in total body bathing of infants and scrubbing of large burn wounds. The Food and Drug Administration challenges the effectiveness of hexachlorophene per se in prevention of staphylococcal disease rather than the remainder of concomitant procedures used in operating nurseries.[1] Esplin expresses surprise at the maintained popularity of hexachlorophene in preoperative preparation of surgeon and patient.[2] He states that iodophores are superior but they produce a brownish discoloration which may not be acceptable in all circumstances.

Whatever proven effectiveness of hexachlorophene or whatever consideration of controversial high doses used in toxicologic studies, at this point the physician is struck with the FDA's medico-

legal implications. The FDA and the American Academy of Pediatrics' Committee on Fetus and Newborn recommend stopping total body bathing of newborn infants with this antiseptic. In addition, scrubbing large denuded burn areas with hexachlorophene is not advisable.

Most nursery and other hospital-acquired infections are directly transmitted from patient or personnel to other patients by means of contaminated hands. This chain could be broken by scrupulous washing before and just after handling each patient and avoidance of breaks in technique.[10] Either an iodophor preparation or a 3% hexachlorophene emulsion is recommended. An Infection Control Program should be instituted in each nursery so that surveillance is provided, especially for the staphylococcal infections, during the babies' stay and for 14 days after discharge. This last aspect may be accomplished with a postcard returned by the mother reporting the presence or absence of skin infection. If the incidence of staphylococcal infections should increase, the hospital epidemiologist can recommend temporary resumption of hexachlorophene bathing which, under these circumstances, is the lesser of two evils until the situation has cleared.[10] Indeed there is no evidence of human toxicity produced by hexachlorophene products under normal conditions of use, although surveillance should be concentrated in that field.

In summary, it should be emphasized that hexachlorophene is an irritating substance. It is absorbed through intact and denuded skin and can cause central nervous system pathology. Under normal circumstances large body areas should not be scrubbed with this antiseptic. Hexachlorophene can still be used for handwashing by hospital personnel. In impending epidemics of staphylococcal skin infections in the nursery, hexachlorophene might be used again temporarily during the period.

References are available upon request from the authors.

Alexander G. Vandevelde, M.D.
Division of Infectious Diseases, Department of Medicine, University Hospital of Jacksonville

E. Charlton Prather, M.D., Chief
Bureau of Preventable Diseases
Florida Division of Health
Jacksonville

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Lobular Carcinoma

Richard M. Fleming, M.D.

Doctors Shocket, Snyder and Benson have called our attention to an alternative method of managing this controversial breast lesion, lobular carcinoma-in-situ on page 25 of this issue. Subcutaneous mastectomy may be used for other precancerous lesions of the breast such as severe forms of fibrocystic disease. It can also be considered in certain local non-infiltrating carcinomas such as intraductal carcinoma, papillary cancer confined to ducts and small colloid or comedocarcinomas without stromal invasion.

If a subcutaneous mastectomy is elected, there are few conditions in which the nipple cannot be preserved. (The case reported here had associated nipple disease). Lobular carcinoma-in-situ, as the name indicates, is a disease of the lobules or terminal lobular ducts. Although clinically some of the tumors may present near the areolar margin, the sub-areolar lactiferous ducts are never involved primarily. A careful dissection of the lactiferous ductal apparatus from the nipple exposing the breast capsule beneath the areola, will effectively eliminate all breast tissue in this area. If one dissects too closely to the nipple (and this is sometimes necessary) the blood supply to the nipple may be impaired and there may be some superficial necrosis or even partial loss of the nipple. Even so, regeneration is the rule and the cosmetic result is quite satisfactory. In those instances where the blood supply is in doubt, the prosthesis should not be inserted as an initial procedure.

Placement of the prosthesis beneath the pectoralis major muscle has been advocated recently and apparently is quite satisfactory. This would obviate the possibility of skin necrosis exposing the underlying prosthesis which would then have to be removed.

I am more concerned when doing a subcutaneous mastectomy in being sure that a total mastectomy is performed, removing all the breast tissue including the axillary tail. Normally, one can do this readily through a submammary incision, which can be quite generous. In a large breast and/or a prominent axillary tail, it may be difficult to get to this area from a submammary incision. In this case a transverse incision can be employed at nipple level, encircling the areola on the upper margin and reflecting the skin in both directions. This technique was suggested by Kleinfeld and Snyder[1] and I have had reason to use it on several occasions when doing a subcutaneous mastectomy in patients who had previously had a biopsy through a circumareolar incision with a transverse extension on one side. The old scar is excised and the transverse arm extended to the other side.

Finally, a word of caution about overtreating a "diagnosis." There have not been enough cases reported in any one series to draw any firm conclusions about non-invasive lobular carcinoma in situ. I feel that while it seems prudent at this time to treat this lesion by total mastectomy (because of the frequency of mulicentricity), it is by no means certain that lobular carcinoma-in-situ progresses to infiltrating cancer as regularly as some series would indicate.

As for the opposite breast, despite the reported high incidence of bilaterality of lobular carcinoma-in-situ, evidence is inconclusive as to proper management of this disease. Routine biopsy of the opposite breast and mastectomy when lobular carcinoma-in-situ is found, is probably no more effective treatment than observing this breast until there is physicial or mammographic evidence of an abnormality.

Invasive lobular carcinoma should be treated as any other invasive breast cancer.

1. Kleinfeld, George and Snyder, Gilbert B.—Unpublished data

Dr. Fleming, 1688 Meridian Avenue, Miami Beach 33139.

Lofty Hemorrhoids

Mr. H.H., 55, high steel construction worker. For several years, other medications provided little or no relief from pain, burning, and itching of internal and external hemorrhoids. Made worse by much heavy lifting which increased pressure in the intrahemorrhoidal plexus. "It wasn't serious enough," so he procrastinated in consulting a doctor. Was also afraid the doctor might find something really serious. Bright blood appearing in the toilet bowl and on toilet tissue scared him into seeing doctor. However, careful history and examination disclosed internal hemorrhoids.



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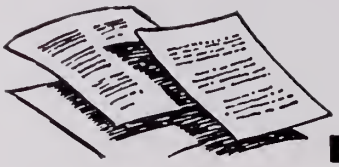
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ANGP-24



Letters

Dear Editor:

The January issue of J.F.M.A. is worthy of special commendation. Not that all other issues of this Journal have not been excellent, but the January issue was noteworthy because of the amount of medical news, information, organizational news, etc., it contained besides the excellent short scientific articles. Above all, it contained an editorial which indeed was a stand out. It should be preserved for posterity so that others in the future might quote from it just as you quoted from Ben Franklin.

Yet, without intending to detract from what I said, I must point out an inconsistency between your quote of Ben Franklin and the last paragraph in your editorial. Franklin said that "time is the stuff life is made of." In contradiction, your last paragraph states "since life is measured by thought and action, not time. . . ."

Oh well, in the final analysis, I'm sure that life is measured by a little of all the things which Ben Franklin and you enumerate.

FRANKLIN J. EVANS, M.D.
CORAL GABLES

Dear Editor:

I am editing a book on the role of faith or religion in healing from a physician's standpoint.

Any physician interested in contributing to this book, please write to the following address:

Claude A. Frazier, M.D.
4-C Doctors Park
Asheville, N.C. 28801

DOCTOR, MARK THESE

DATES ON YOUR CALENDAR:

MAY 3-7, 1972

Ninety-Eighth Annual Meeting

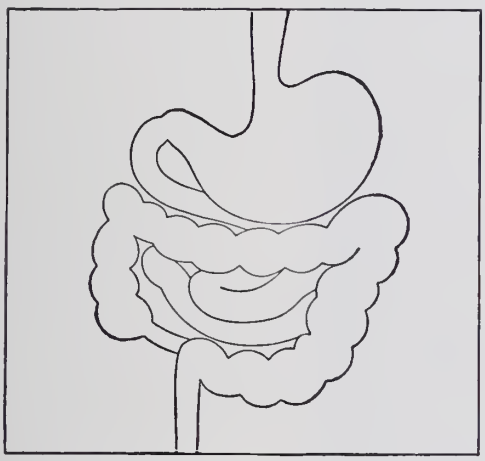
FLORIDA MEDICAL ASSOCIATION

DIPLOMAT HOTEL

HOLLYWOOD

See preliminary program page 58

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Governor Reubin O'D. Askew to Address 98th FMA Convention



GOVERNOR ASKEW

Governor Reubin O'D. Askew will deliver the annual Baldwin Lecture at the 98th Annual Meeting of the Florida Medical Association next month at 11:00 a.m., Friday, May 5, at Hollywood-by-the-Sea.

Emerging rapidly as a national political figure, Governor Askew was tapped recently to deliver the Keynote Address for the Democratic National Convention at Miami Beach this summer. He has been mentioned by some prominent Democrats as a possible candidate for their nomination for the Vice Presidency.

One of six children, the Governor was born at Muskogee, Oklahoma in 1928. The family moved to Pensacola in 1937, which has been his hometown since.

He served in the military twice, first as a sergeant in the Army and later as a captain in the Air Force. He received a B.S. degree from Florida State University, and later entered the University of Florida Law School, where he was awarded his LL.B. degree in 1956.

His first public service position was Assistant Solicitor of Escambia County. He was elected to the Florida House of Representatives in 1958, and was elevated to the State Senate four years later.

It was as a State Senator in 1970 that Mr. Askew waged an uphill campaign that netted him first the Democratic nomination for governor. He went on to defeat incumbent Republican Governor Claude Kirk in the general election.

The Governor is married to the former Donna Lou Harper of Sanford and they have two children, Angela and Kevin.

Schedule Of Activities

FLORIDA MEDICAL ASSOCIATION ANNUAL MEETING

Diplomat Hotel, Hollywood-by-the-Sea, May 3-7, 1972

WEDNESDAY, MAY 3

10:00 a.m.	General Registration and Delegates Registration, Foyer, Convention Hall
2:00 p.m.	Delegates Registration, Foyer, Convention Hall
4:00 p.m.	First House of Delegates, Regency Room

THURSDAY, MAY 4

8:00 a.m.	Blue Shield Annual Meeting, Regency Room
8:30 a.m.	Exhibits Open Daily until 4:30 p.m., Convention Hall
9:30 a.m.	Reference Committee No. I, Embassy Room
	Reference Committee No. V, Convention Hall A
10:00 a.m.	Reference Committee No. II, Tack Room
	Reference Committee No. IV, Convention Hall B
10:30 a.m.	Reference Committee No. III, Card Room
2:00 p.m.	FMA Scientific Sections (See official program)

FRIDAY, MAY 5

9:00 a.m.	FMA Scientific Sections (See official program)
11:00 a.m.	General Session (Baldwin Lecture), Regency Room
12:15 p.m.	Woman's Auxiliary and FLAMPAC Luncheon, Les Ambassadeurs
2:30 p.m.	FMA Scientific Sections (See official program)
6:30 p.m.	President's Reception, Poolside
7:30 p.m.	Alumni and Fraternity Socials (See official program)

SATURDAY, MAY 6

9:00 a.m.	FMA Scientific Sections (See official program)
All day	Specialty Group Meetings (See official program)
1:00 p.m.	Delegates Registration, Foyer, Convention Hall
3:00 p.m.	Second House of Delegates, Regency Room
Evening	Specialty Group Socials (See official program)

SUNDAY, MAY 7

7:30 a.m.	Delegates Registration, Foyer, Convention Hall
9:00 a.m.	Third House of Delegates, Regency Room

VISIT EXHIBITS 8:30 A.M.-4:30 P.M. DAILY

Please inquire at the registration desk for information on the following available sports:

Golf Tournament—Ray E. Murphy Jr., M.D., Chairman

Tennis Tournament—Joel Schneider, M.D., Chairman
Richard G. Connar, M.D., Co-Chairman

Fishing—Hobart T. Feldman, M.D., Chairman





1972 FLORIDA MEDICAL ASSOCIATION

98th Annual Meeting

Diplomat Hotel, Hollywood-by-the-Sea, Florida

May 3 - 7, 1972

	May 3 Wednesday	May 4 Thursday	May 5 Friday	May 6 Saturday	May 7 Sunday
A. M.	Set Up EXHIBITS 10:00 General and Delegates Registration	8:00 Blue Shield Annual Mtg. 9:30 Ref. Comm. Nos. V & I 10:00 Ref. Comm. Nos. IV & II 10:30 Ref. Comm. No. III VISIT EXHIBITS	9:00 Scientific to Sections and 10:45 Specialty Groups VISIT EXHIBITS 11:00 General Session (Baldwin Lecture)	9:00 Specialty Groups and Scientific Sessions VISIT EXHIBITS	9:00 Third House of Delegates
P. M.	4:00 First House to of Delegates 5:30	2:00 Scientific Sections 5:00 (Reference Committees, if necessary)	12:15 Aux. & FLAMPAC to Luncheon 2:00 2:30 Scientific to Sections and 5:00 Specialty Groups	1:00 Specialty to Groups 2:45 3:00 Second House of Delegates	Post- Convention Board of Governors
E v e n i n g			6:30 President's Reception 7:30 Alumni & Fraternity Socials	Dismantle Exhibits Specialty Groups Socials	

Annual Meeting Specialty Programs

Section on Chest Medicine

(Co-sponsored by Florida Chapter, American College of Chest Physicians)

Thursday, May 4

Eugene J. Sayfie, M.D., Miami, Program Chairman

2:00 p.m. "The Clot and the Thrombus: Current Trends in Pathogenesis and Treatment"—Jack Hirsh, M.D., Professor, Departments of Medicine and Pathology, McMaster University Faculty of Medicine, Hamilton, Ontario, Canada.

3:00 p.m. Fireside Conferences:

1. "Chest X-Ray: Your Diagnosis"—Manuel Viamonte Jr., M.D., Miami.
2. "Prolonged Ventilatory Support: Problems and Management"—E. F. Klein, M.D., Gainesville; Dean D. Merganthaler M.D., West Palm Beach; Jay D. Williams Jr., M.D., Pensacola.
3. "Adult Respiratory Distress Syndrome: 'Pump-Shock-Lung' "—Marvin A. Sackner, M.D. and Roberto Llamas, M.D., Miami Beach.
4. "Coronary Vascular Surgery: For the Multitude or the Select Few?"—Jonathan O. Partain, M.D., Orlando; George R. Daicoff, M.D., Gainesville; Ernest A. Traad, M.D., Miami.
5. "Mechanisms of Arrhythmias: Re-entry, Automoticity and Concealed Conductions"—Agustin Castellanos Jr., M.D. and John Lister, M.D., Miami.
6. "Myocardial Infarctions Re-visited: Pathogenesis and Therapy" — Jack Hirsh, M.D., Hamilton, Ontario, Canada; Jerome Benson, M.D., Miami Beach; Rodrigo A. Bustamante M.D., Coral Gables; Richard A. Elias, M.D., Miami.

Section on Emergency Medicine

(Co-sponsored by Florida Chapter, American College of Emergency Physicians)

Thursday, May 4

William T. Haeck, M.D., Jacksonville, Program Chairman

2:00 p.m. "Allowing Peer Review to Work in the Emergency Department"—John L. Buckingham, M.D., Tampa.

2:45 p.m. "Emergency Medical Services for Florida" —Herman E. Hilleboe, M.D., Tampa.

3:30 p.m. "Emergency Medical Services Councils"—Major William Gemma, Columbus, Ohio.

Section on Allergy

(Co-sponsored by Florida Allergy Society)

Friday, May 5

Bernard M. Barrett, M.D., Pensacola, Program Chairman

2:30 p.m. "Management of Acute Respiratory Distress in Adults"—Wilbur G. Avery, M.D., Miami Beach.

Section on Family Practice and Psychiatry

(Co-sponsored by Florida Academy of Family Physicians and Florida Psychiatric Society)

Friday, May 5

Donald G. Nikolaus, M.D., Dunedin, Program Chairman

2:30 p.m. "Hallucinogens and Physician's Community Involvement"—David J. Lehman Jr., M.D., Hollywood.

3:00 p.m. Break

3:15 p.m. Panel Presentation—"Breast Cancer: Early Diagnosis, Treatment, Rehabilitation and Follow-up; Psychiatric Aspects of Each"

Panelists: Guy F. Robbins, M.D., Surgeon, New York Memorial Hospital, New York, New York; Rubin Klein, M.D., Radiotherapist, Hollywood; Robert L. Egan, M.D., Department of Radiology, Emory University School of Medicine, Atlanta, Georgia; Arthur Fleming, M.D., Department of Psychiatry, University of Florida College of Medicine, Gainesville.

Section on Medicine

(Co-sponsored by Florida Society of Internal Medicine and American College of Physicians)

Friday, May 5

Program Chairmen:
Chester Cassel, M.D., Miami
Jess V. Cohn, M.D., Ft. Lauderdale

"Psychiatry for Internists"
Moderator: Chester Cassel, M.D.

9:00 a.m. "Is the Internist Involved in Psychiatry?"—Chester Cassel, M.D., Miami.

9:15 a.m. "The Art of Interviewing"—Leo H. Bartemeier, M.D., Baltimore, Maryland.

9:35 a.m. "Brief Psychotherapy and Handling Difficult Patients"—Jess V. Cohn, M.D., Fort Lauderdale.

9:55 a.m. "Pharmacologic Treatment of Anxiety and Depression in Medical Patients"—Burton J. Goldstein, M.D., Associate Professor of Psychiatry, University of Miami School of Medicine, Miami.

10:15 a.m. Audience Questions and Panel Answers.

Section on Otolaryngology

(Co-sponsored by Florida Society of Otolaryngology)

Friday, May 5

J. Ryan Chandler, M.D., Miami, Program Chairman

9:00 a.m. "Surgery of the Ethmoid and Frontal Sinuses"—J. Andrew Burnam, M.D., Instructor in Otolaryngology, University of Miami School of Medicine, Miami.

9:15 a.m. "Neoplasms of the Head and Neck in Children"—William G. Hemenway, M.D.,* Professor and Chief, Division of Otolaryngology, University of Colorado School of Medicine, Denver, Colorado.

9:45 a.m. "Sexual Aspects of the Nose"—Jerry Margolin, M.D., Clearwater.

10:00 a.m. "Iatrogenic Rhinitis"—Karl Morgenstein, M.D., Hollywood.

10:15 a.m. "Referred Otalgia"—Paul L. Goethals, M.D., Winter Park.

*This speaker made possible by a grant from the Florida Division, American Cancer Society.

Section on Otolaryngology and Pediatrics

(Co-sponsored by Florida Society of Otolaryngology and Florida Pediatric Society)

Friday, May 5

Program Chairmen:
J. Ryan Chandler, M.D., Miami
George A. Richard, M.D., Gainesville

1:30 p.m. "Congenital Ear Surgery"—Brian Hardcastle, M.D., Assistant Professor of Otolaryngology, University of Florida College of Medicine, Gainesville.

1:45 p.m. "Identification and Management of Deafness in Children"—William G. Hemenway, M.D.,* Professor and Chief, Division of Otolaryngology, University of Colorado School of Medicine, Denver, Colorado.

2:15 p.m. "Craniofacial Anomalies"—Samuel Berkowitz, D.D.S., Clinical Assistant Professor of Pediatrics, University of Miami School of Medicine, Miami.

2:35 p.m. "Indications for Cytogenetic Studies"—Jaime Frias, M.D., Assistant Professor of Pediatrics, University of Florida College of Medicine, Gainesville.

3:00 p.m. Intermission

3:30 p.m. "Role of the Adenoids and Tonsils in Occlusal Disorders"—Virgil A. Ponzoli Jr., M.D., Naples.

3:45 p.m. "Sinusitis in Childhood"—William R. Hudson, M.D., Professor and Chief, Division of Otolaryngology, Duke University School of Medicine, Durham, North Carolina.

4:15 p.m. "Serous Otitis Media"—Franklin Owen Black, M.D., Associate Professor of Surgery, University of Florida College of Medicine, Gainesville.

4:35 p.m. "Immune Deficiencies as They Relate to Infections of the Ears and Tonsils"—Martin L. Schulkind, M.D., Assistant Professor of Pediatrics, University of Florida College of Medicine, Gainesville.

*This speaker made possible by a grant from the Florida Division, American Cancer Society.

Section on Preventive Medicine

(Co-sponsored by Florida Society of Preventive Medicine)

Friday, May 5

Joseph A. Baird, M.D., Bradley, Program Chairman

"HEALTH AND THE WORKER"

2:30 p.m. "Challenges in Industrial Health"—Roma D. Reyner, R.N., President, Florida State Association of Industrial Nurses; Palm Beach County Health Department, West Palm Beach.

3:15 p.m. "Occupational Medicine in Latin America"—Rafael A. Peñalver, M.D., Director, Office of International Medical Education, University of Miami School of Medicine, Miami.

4:00 p.m. "Preventive Medicine in the United States Air Force"—Paul F. Nugent, Colonel, USAF, MC, Chief, Preventive Medicine Branch, Office of the Surgeon General, U.S. Air Force, Washington, D.C.

Section on Radiology

(Co-sponsored by Florida Radiological Society)

Friday, May 5

Joel H. Gilbert, M.D., Miami, Program Chairman

2:30 p.m. "A Practical Radiological Approach to Articular Disease"—Philip J. Hodes, M.D., Professor of Radiology, University of Miami School of Medicine, Miami; Professor Emeritus, Jefferson Medical College, Philadelphia, Pennsylvania.

3:15 p.m. "Special Procedures in the Community Hospital"—Manuel Viamonte Jr., M.D., Professor and Chairman, Department of Radiology, University of Miami School of Medicine, Miami.

4:00 p.m. Break

4:15 p.m. "A Simplified Approach to the Diagnosis of Localized Lesions of Bone"—Gwilym S. Lodwick, M.D., Professor and Chairman, Department of Radiology, University of Missouri School of Medicine, Columbia, Missouri.

Section on Orthopedic Surgery

(Co-sponsored by Florida Orthopedic Society)

Friday, May 5

Davis S. Boling, M.D., Tampa, Program Chairman

3:00 p.m. "Tumors of the Foot"—Howard P. Hogshead, M.D., Associate Professor of Orthopedic Surgery, University of Florida College of Medicine, Gainesville.

3:20 p.m. "Nerve Tumors of the Lower Extremity"—Robert P. Keiser, M.D., Clinical Professor of Orthopedic Surgery, University of Miami School of Medicine, Coral Gables.

3:50 p.m. "Bone Tumors: Clinical Aspects"—Kenneth C. Francis, M.D., Associate Professor of Clinical Orthopedic Surgery, New York University School of Medicine, New York.

4:10 p.m. "Bone Tumors: Immunological and Microscopic Aspects"—Homer G. Paschall, M.D., Assistant Professor of Orthopedic Surgery, University of Florida College of Medicine, Gainesville.

4:30 p.m. "Radiation Therapy of Bone Tumors"—Ralph Jensen, M.D., Tampa.

4:50 p.m. Round Table Discussion of Bone Tumors with Audience Participation—Panelists: Drs. Francis, Paschall, and Jensen.

Section on Dermatology

(Co-sponsored by Florida Society of Dermatology)

Saturday, May 6

Philip Frost, M.D., Miami, Program Chairman

9:00 a.m. Program to be announced.

Section on Medicine

(Co-sponsored by Florida Society of Internal Medicine and American College of Physicians)

Saturday, May 6

Peter S. Irving, M.D., Hollywood, Program Chairman

"NEUROLOGY FOR INTERNISTS"

Moderator: Victor Hochberg, M.D., Hollywood

9:00 a.m. "Parkinsonism and Essential Tremor"—Oscar M. Reinmuth, M.D., Professor of Neurology, University of Miami School of Medicine, Miami.

9:30 a.m. "Vertigo"—Noble J. David, M.D., Professor of Neurology and Associate Professor of Ophthalmology, University of Miami School of Medicine; Chief of Neurology, Veterans Administration Hospital, Miami.

10:00 a.m. "Dementias"—Kenneth H. Heilman, M.D., Assistant Professor of Medicine and Neurology, University of Florida College of Medicine, Gainesville.

10:30 a.m. Panel Discussion—Drs. Reinmuth, David, Heilman and Hochberg.

Section on Ophthalmology

(Co-sponsored by Florida Society of Ophthalmology)

Saturday, May 6

James A. Stokes, M.D., Orlando, Program Chairman

9:00 a.m. "Diabetic Retinopathy: Treatment by Laser and Photocoagulation"—Speakers: Guy E. O'Grady, M.D., Bascom Palmer Eye Institute, University of Miami School of Medicine, Miami; William A. Newsom, M.D., Department of Ophthalmology, University of Florida College of Medicine, Gainesville.

Section on Pathology

(Co-sponsored by Florida Society of Pathologists)

Saturday, May 6

Jerome Benson, M.D., Miami Beach, Program Chairman

1:15 p.m. "The Significance of the Histologic Manifestations of Hodgkin's Disease in Therapy and Prognosis"—Robert J. Lukes, M.D.. Professor of Pathology, University of Southern California School of Medicine, Los Angeles, California.

Section on Pediatrics

(Co-sponsored by Florida Pediatric Society)

Saturday, May 6

George A. Richard, M.D., Gainesville, Program Chairman

Moderator: Paul B. Welty, M.D., St. Petersburg

8:30 a.m. "First . . . A Child" (Film of Florida's camp for children and youth with Diabetes Mellitus)—Arlan L. Rosenbloom, M.D., Associate Professor of Pediatrics, University of Florida College of Medicine, Gainesville.

9:00 a.m. "Thymic Transplant: Current Experience and Follow-up"—William W. Cleveland, M.D., Professor and Chairman, Department of Pediatrics, University of Miami School of Medicine, Miami.

9:25 a.m. "Training Office Personnel to Assist Physicians"—William A. Altemeier, M.D., Assistant Professor of Pediatrics, University of Florida College of Medicine, Gainesville.

9:50 a.m. "Management of Cardiac Arrhythmia in Childhood"—Henry Gelband, M.D., Assistant Professor of Pediatrics, University of Miami School of Medicine, Miami.

10:15 a.m. "Hutchinson-Gilford-Progeria Syndrome"—Franklin L. DeBusk, M.D., Associate Professor of Pediatrics and Director of Pediatric Outpatient Clinics, University of Florida College of Medicine, Ganesville.

10:40 a.m. Break

10:50 a.m. Moderator: Warren W. Quillian, M.D.

"Radiologic Evaluation of Abdominal Masses in Childhood"—Alvin H. Felman, M.D., Assistant Professor of Radiology and Chief of Pediatric Radiology, University of Florida College of Medicine, Gainesville.

11:15 a.m. "Management of Respiratory Distress Syndrome of the Newborn"—Eduardo Bancalari, M.D., Instructor of Pediatrics, University of Miami School of Medicine, Miami.

11:40 a.m. "Parenteral Hyperalimentation: Indications, Technique and Potential Pitfalls"—James L. Talbert, M.D., Professor of Surgery and Chief of Pediatric Surgery, University of Florida College of Medicine, Gainesville.

Section on Plastic and Reconstructive Surgery

(Co-sponsored by Florida Society of Plastic and Reconstructive Surgery)

Saturday, May 6

Alvaro Alfonso, M.D., West Palm Beach, Program Chairman

9:00 a.m. "Another Method for Repairing Large Defects of the Inner Cheek"—Grover W. Austin, M.D., St. Petersburg.

"Recontouring of the Sagging Abdomen"—Bruce E. Walton, M.D., Gainesville.

"Esthetic Surgery of the Facial Skeleton"—James H. Hendrix Jr., M.D., Professor and Chairman, Division of Plastic Surgery, University of Mississippi School of Medicine, Jackson, Mississippi.

Section on Radiology

(Co-sponsored by Florida Radiological Society)

Saturday, May 6

Joel H. Gilbert, M.D., Miami, Program Chairman

9:00 a.m. "Emergency Conditions of the Newborn"—Donald H. Altman, M.D., Clinical Professor of Radiology, University of Miami School of Medicine and Director of Radiology, Variety Children's Hospital, Miami.

9:40 a.m. "Role of Radiation Therapy in the Palliation of Malignant Disease"—Komanduri K. N. Charyulu, M.D., Professor of Radiology and Director, Department of Radiation Therapy, University of Miami School of Medicine, Miami.

10:15 a.m. Break

10:30 a.m. "Diverticular Disease of the Colon"—Philip J. Hodes, M.D., Professor of Radiology, University of Miami School of Medicine, Miami; Professor Emeritus, Jefferson Medical College, Philadelphia, Pennsylvania.

11:15 a.m. "The Computer and Diagnostic Radiology"—Gwilym S. Lodwick, M.D., Professor and Chairman, Department of Radiology, University of Missouri School of Medicine, Columbia, Missouri.

Section on Colon and Rectal Surgery

(Co-sponsored by Florida Proctologic Society)

Saturday, May 6

Manuel L. Carbonell, M.D., Miami, Program Chairman

9:30 a.m. "Management of Presacral Tumors" (film and discussion)—Patrick Hanley, M.D., Professor and Head, Department of Colon and Rectal Surgery, Tulane University School of Medicine and Head, Colon and Rectal Surgery, Ochsner Clinic, New Orleans, Louisiana.

10:30 a.m. Exhibits.

11:00 a.m. "Condyloma Accuminata: A New Epidemic"—George Williams, M.D., Miami.

Section on Pediatric Surgery

(Co-sponsored by Florida Association of Pediatric Surgeons)

Saturday, May 6

H. Warner Webb, M.D., Jacksonville, Program Chairman

1:00 p.m. Case presentations of interesting pediatric surgical problems with open discussion.

Section on Thoracic Surgery

(Co-sponsored by Florida Thoracic Surgical Society)

Saturday, May 6

Charles H. Lasley, M.D., Clearwater, Program Chairman

"THE PROBLEM: WHAT TO DO"

Moderator: Francis N. Cooke, M.D., Miami

1:30 p.m. "When Your Bronchoscope Fills with Blood"—DeWitt C. Daughtry, M.D., Miami.

"With Neurovascular Compression of the Thoracic Outlet"—Richard H. Blank, M.D., Tampa.

"To Obtain Long-Term Survival in Cancer of the Esophagus"—Robert B. Trumbo, M.D., Orlando.

Scientific and Educational Exhibits Convention Hall

A-B	"Scope of Plastic Surgery"—Dorthea Weybright, M.D., West Palm Beach.
C	"The Physician's Role in the Voluntary Health Movement"—Frank L. Creel, M.D., Pensacola; Mr. Henry F. Hunter, St. Petersburg and Mrs. Jean Robinson, Orlando.
D	"Treatment of Snake Bite"—Ralph E. Peterson, M.D. and William J. Bailey, M.D., Naples.
E-F	"Preinfarctional Syndrome—Definition, Diagnostic Measures and Therapy"—Thomas O. Gentsch, M.D., Parry B. Larsen, M.D. and Ernest A. Traad, M.D., Miami.
G	"Referred Otalgia"—Paul L. Goethals, M.D., Winter Park.
H	"The Many Faces of Vocational Rehabilitation"—A. E. Ogden, M.D., Tallahassee.
J	"Protein Immunoelectrophoresis"—Francisco Civantos, M.D., John di Bella, M.D., Carlos J. Dominguez, M.D. and Arkadi M. Rywlin, M.D., Miami Beach.
K	"Spasticity and its Management"—Pedro Arroyo Jr., M.D., Miami.
L	"Bureau of Alcoholic Rehabilitation, State of Florida"—Helen M. Williams, M.D. and Mr. Ken Doig, Avon Park.
M	"Diagnosis and Treatment of Cancer in Children"—William H. Donnelly, M.D. and Rosilie O. Saffos, M.D., Gainesville.
N-O	"Adenomammectomy with Immediate Breast Reconstruction"—Thomas J. Zaydon, M.D., Harold G. Norman, M.D. and Ian D. Thompson, M.D., Miami.
P-Q	"Otologic Disease in Family Practice"—L. Alan Smith, B.S. (M-4) and Fredric W. Pullen II, M.D., Miami.
R-S	"Diabetes Mellitus: Under Good Diagnostic Protocol"—James M. Moss, M.D., C. Robert Meloni, M.D. and Edward J. Gallagher, M.D., Alexandria, Virginia.
T-U	"Diet vs. Drug Treatment of Hyperlipidemia"—Donald Berkowitz, M.D., Philadelphia, Pennsylvania.
V	"Emergency Medical Services"—Granville W. Larimore, M.D. and Mr. Harold A. Tyler, Tampa.
W-X-Y-Z	"Health Profile Screening for Physicians"—James E. Fulghum, M.D. and Marshall E. Groover Jr., M.D., Jacksonville.

Congressman Wilbur Mills To Speak At FMA Annual Meeting



Congressman Mills

Congressman Wilbur D. Mills of Arkansas will speak at a luncheon held in conjunction with the 98th Annual Meeting of the Florida Medical Association next month.

Joseph C. Von Thron, M.D., of Cocoa Beach, President of the Florida Medical Political Action Committee (FLAMPAC), announced that Congressman Mills would speak at a luncheon beginning at 12:15 on Friday, May 5, at the Diplomat Hotel in Hollywood-by-the-Sea. The annual luncheon is sponsored by FLAMPAC and the Woman's Auxiliary to the Florida Medical Association.

As Chairman of the powerful House Ways and Means Committee, Mr. Mills is among the most influential members of the Congress. His Committee held hearings last year on several national health insurance proposals before Congress and probably will play an important role in whatever legislation is eventually enacted.

A native of Kensett, Ark., Congressman Mills attended Hendrix College and Harvard Law School. He has served in Congress since 1939 and has chaired the Ways and Means Committee since 1958.

"The New Directions," a singing group from the Riverside Baptist Church in Miami, will provide entertainment for the luncheon.

Keynote Speaker-WA / FMA

Mrs. G. Prentiss Lee, President of the Woman's Auxiliary to the American Medical Association, will be the keynote speaker during the first session of the Woman's Auxiliary House of Delegates on Thursday morning, May 4.

Mrs. Lee, a native of Oregon, is the mother of three children. She has been involved in multiple civic activities and, in addition, has taken an active role in the development of the commercial holly industry. Her husband, a diplomate of the American Board of Surgery, is a general surgeon.



Mrs. Lee

WOMAN'S AUXILIARY TO THE FLORIDA MEDICAL ASSOCIATION, INC.

Forty-fourth Annual Meeting—May 3-7, 1972

Diplomat Hotel, Hollywood, Florida

The Woman's Auxiliary to the Palm Beach County Medical Society is pleased to join with Mrs. Wesley Nock our president, in issuing to all of you the "Annual Call to Convention." We look forward to seeing you at the Diplomat Hotel, May 3, 4, and 5 for three full days of fun and activity.

Mrs. James Brandon and Mrs. Dan Tucker
Convention Chairmen

DAILY SCHEDULE

Wednesday, May 3	
10:00 a.m. and 2:00 p.m.	General Registration. FMA Registration, Convention Hall
12:30—5:00 p.m.	Registration for all State Officers, Chairmen and County Presidents, Entrance Mezzanine Theatre Pre-Registration for House of Delegates, Entrance Mezzanine Theatre Pre-registration for Awards and FLAMPAC luncheons
	Art Show entries accepted in Exhibit Hall
12:00—1:30 p.m. & 4:00—5:00 p.m.	County Reports, Exhibits and Doctors' Day Scrapbooks set-up in Mezzanine Theatre
11:00 a.m.	Executive Committee Meeting—Suite of President and President-Elect
1:30 p.m.	Pre-Convention Board of Directors meeting, Mezzanine Theatre, Mrs. Wesley S. Nock, presiding
Thursday, May 4	
7:30—8:45 a.m.	Complimentary Continental Breakfast, Entrance Mezzanine Theatre
8:00 a.m.—3:00 p.m.	Registration for all Officers, Chairmen, County Presidents and Delegates to the House of Delegates, Entrance Mezzanine Theatre
9:00 a.m.—12 noon	First Session of House of Delegates. All Auxiliary members invited. Delegates, please sit with your delegation and wear badges. Keynote speaker, Mrs. G. Prentiss Lee, President of the Woman's Auxiliary to the American Medical Association. Special guest, Mrs. Raymond E. Jones, President of the Woman's Auxiliary to the Southern Medical Association.
12:15 p.m.	AWARDS LUNCHEON. Honoring our Past Presidents, Cafe Cristal
2:30—5:00 p.m.	Second Session of the House of Delegates, Mezzanine Theatre
Friday, May 5	
9:00 a.m.	Post-Convention Board of Directors Meeting, Mezzanine Theatre. State and County Officers and Chairmen for 1972-73 please attend. Mrs. James J. DeVito presiding.
12:15 p.m.	AUXILIARY-FLAMPAC Luncheon, Les Ambassadeurs. Speaker, Representative Wilbur D. Mills, Arkansas. Music by South Baptist Church Choir of Miami

Please make your reservations for rooms directly with the hotel, with a notation that you will be attending the FMA Auxiliary Annual Meeting.

THE ART SHOW AT THE ENTRANCE TO THE CONVENTION HALL

VISIT AUXILIARY BOOTH IN THE EXHIBIT HALL

ART SHOW AWARDS PRESENTED AT LUNCHEON ON THURSDAY

When other builders start building boats our way there may be other boats just as good



The new V-21 Apollo
Single or twin outboard
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Pinworm therapy is often a family affair





Contraindications: History of hypersensitivity to thiabendazole.
Warnings: If hypersensitivity reactions occur, drug should be discontinued immediately and not resumed. Rarely, erythema multiforme has been associated with thiabendazole therapy; in severe cases (Stevens-Johnson syndrome), fatalities have occurred. Because CNS side effects may occur quite frequently, activities requiring mental alertness should be avoided. Safe use in pregnancy or lactation has not been established.
Precautions: Ideally, supportive therapy is indicated for anemic, dehydrated, or malnourished patients prior to initiation of anthelmintic therapy. In presence of hepatic or renal dysfunction, patients should be carefully monitored.
Adverse Reactions: Most frequently encountered are anorexia, nausea, vomiting, and dizziness. Less frequently, diarrhea, epigastric distress, pruritus, weariness, drowsiness, giddiness, and headache have occurred. Rarely, tinnitus, hyperirritability, numbness, abnormal sensation in eyes, blurring of vision, xanthopsia; hypotension, collapse; enuresis; transient rise in cephalin flocculation and SGOT; perianal rash, cholestasis and parenchymal liver damage; hyperglycemia; transient leukopenia malodor of the urine, crystalluria, hematuria; appearance of live Ascaris in the mouth and nose. Hypersensitivity reactions

A New Dosage Form:

Chewable Tablets 500 mg Mintezol®

(THIABENDAZOLE | MSD)



so easy to take
everyone in the family
will keep to the
regimen you prescribe

nclude: fever, facial flush, chills, conjunctival injection, ngioedema, anaphylaxis, skin rashes, erythema multiforme ncluding Stevens-Johnson syndrome), and lymphadenopathy.

upplied: Chewable tablets, containing 500 mg thiabendazole, n boxes of 36, strip packaged, individually foil wrapped; uspension, containing 500 mg thiabendazole per 5 cc, in ottles of 120 cc.

or more detailed information, consult your MSD representa-ive or see the Direction Circular. Merck Sharp & Dohme, ivision of Merck & Co., Inc., West Point, Pa. 19486

addendum

MSD MERCK SHARP & DOHME

INDICATION | DOSAGE SCHEDULE

MINTEZOL® (Thiabendazole, MSD) has demonstrated effectiveness against a broad spectrum of nematode infestations, whether encountered singly or in combination. Dosages are weight related; therefore, a weight-dose chart is included in the Direction Circular for your convenience when writing a prescription. MINTEZOL should be given after meals if possible.

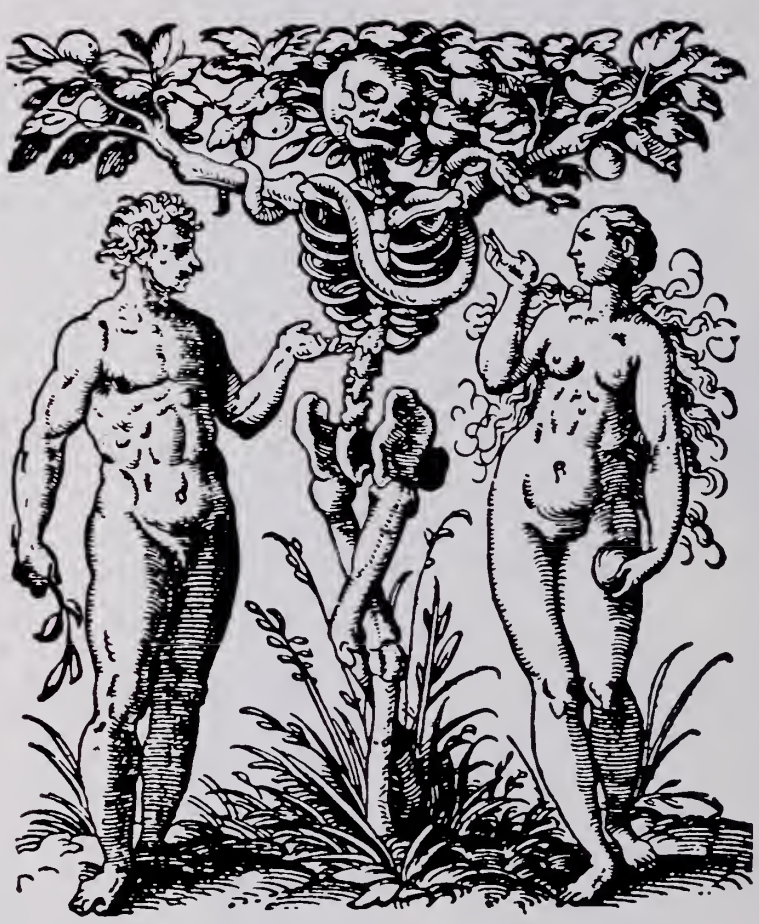
INDICATIONS	DOSAGE (1st Day)	ADDITIONAL REGIMEN	COMMENTS
Pinworm disease	Two doses of 1 tablet/50 lb	Repeat 7 days later	This regimen is designed to reduce the risk of reinfection. However, if not practical, repeat the regimen the next day.
Threadworm,* large roundworm,* hookworm,* and whipworm* disease	Two doses of 1 tablet/50 lb	Repeat the next day	Alternatively, a single dose of 2 tablets/50 lb may be given. However, a higher incidence of side effects should be expected.
Creeping eruption	Two doses of 1 tablet/50 lb	Repeat the next day	If active lesions are still present 2 days after completing this regimen, a second course is recommended.
Symptoms of trichinosis* during the invasive phase of the disease	Two doses of 1 tablet/50 lb	Repeat for 2 to 4 successive days	The optimal dosage for the treatment of trichinosis has not been established.

The recommended maximal daily dosage is 3 g (6 tablets).

*Clinical experience with thiabendazole for treatment of each of these conditions in children weighing less than 30 lb has been limited.

In acute gonorrhea

(urethritis, cervicitis, proctitis when due to susceptible strains of N. gonorrhoeae)



Sterile Trobicin®
(spectinomycin dihydrachlaride pentahydrate)—For Intramuscular injections, 2 gm vials cantaining 5 ml when recanstituted with diluent. 4 gm vials cantaining 10 ml when reconstituted with diluent.
An aminocyclitol antibiatic active *in vitro* against most strains of *Neisseria ganarrhaeae* (MIC 7.5 ta 20 mcg/ml). Definitive *in vitro* studies have shown no cross resistance of *N. gonarrhoeae* between Trobicin and penicillin.

Indications: Acute gonorrheal urethritis and proctitis in the male and acute ganorrheal cervicitis and proctitis in the female when due to susceptible strains of *N. ganarrhaeae*.

Contraindications: Cantraindicated in patients previously found hypersensitive ta Trabicin. Not indicated for the treatment of syphilis.

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Warnings: Antibiotics used to treat gonorrhea may mask delay the symptoms of incubating syphilis. Patients should e carefully examined and monthly serological follow-up fa least 3 manths should be instituted if the diagnosis of syphil suspected.

Safety far use in infants, children and pregnant wamen has been established.

Precautions: The usual precautians shauld be observed atapic individuals. Clinical effectiveness should be manitare detect evidence af development of resistance of *N.gonarrho*

Adverse reactions: The following reactians were abser during the single-dose clinical trials: soreness at the injection s urticaria, dizziness, nausea, chills, fever and insamnia.
During multiple-dase subchronic talerance studies in no human valunteers, the following were nated: a decrease in he

Trobicin®

sterile spectinomycin dihydrochloride pentahydrate, Upjohn

single-dose intramuscular treatment

igh cure rate:* 96% of 571 males, 95% of 294 females
)osages, sites of infection, and criteria for diagnosis and cure are defined below.)**

.ssurance of a single-dose, physician-controlled treatment schedule

lo allergic reactions occurred in patients with an alleged history of penicillin sensitivity 'hen treated with Trobicin, although penicillin antibody studies were not performed

.ctive against most strains of Neisseria gonorrhoeae in vitro (M.I.C. 7.5-20 mcg/ml)

single two-gram injection produces peak serum concentrations averaging about)0 mcg/ml in one hour (average serum concentrations of 15 mcg/ml present 8 hours after dosing)

ote: Antibiotics used in high doses for short periods of time to treat gonorrhea may mask or delay the 'mptoms of incubating syphilis. Since the treatment of syphilis demands prolonged therapy with any fective antibiotic, and since Trobicin is not indicated in the treatment of syphilis, patients being treated for)norrhea should be closely observed clinically. Monthly serological follow-up for at least 3 months should e instituted if the diagnosis of syphilis is suspected. Trobicin is contraindicated in patients previously found 'persensitive to it.

ata compiled from reports of 14 investigators. **Diagnosis was confirmed by cultural identification of *N. gonorrhoeae* on Thayer-artin media in all patients. Criteria for cure: negative culture after at least 2 days post-treatment in males and at least 7 days post-eatment in females. Any positive culture obtained post-treatment was considered evidence of treatment failure even though the llow-up period might have been less than the periods cited above under "criteria for cure" except when the investigator determined at reinfection through additional sexual contacts was likely. Such cases were judged to be reinfections rather than relapses or llures. These cases were regarded as non-evaluatable and were not included. JA72 1846-6

obin; hematocrit and creatinine clearance; elevation of alka-le phosphatase, BUN and SGPT. In single and multiple-dose sdies in normal volunteers, a reduction in urine output was ed. Extensive renal function studies demonstrated no con-sent changes indicative of renal toxicity.

sage and administration: Keep at 25°C ond use within 2 hours after reconstitution with diluent.

ale—single 2 gram dose (5 ml) intramuscularly. Patients with gonorrheal proctitis and patients being re-treated after failure of previous antibiotic therapy should receive 4 grams (10 ml). In geographic areas where antibiotic resistance is known to be pre-valent, initial treatment with 4 grams (10 ml) intromusculorly is preferred.

Female—single 4 gram dose (10 ml) intramuscularly.

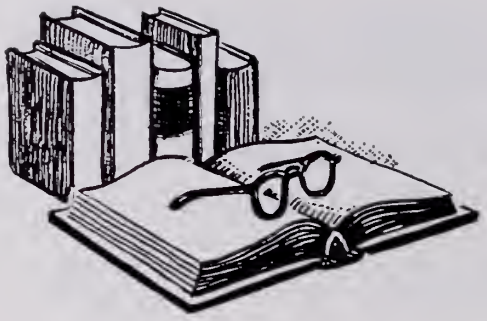
w supplied: *Vials, 2 and 4 grams—with ampoule of Bacteriostatic Water for Injection with Benzyl Alcohol 0.9% w/v.* Reconstitution yields 5 and 10 ml respectively with a concentration of spectinomycin dihydrochloride pentahydrate equivalent to 400 mg spectinomycin per ml. For intramuscular use only.

Susceptibility Powder—for testing *in vitro* susceptibility of *N. gonorrhoeae.*

Human pharmacology: Rapidly absorbed after intromuscular injection. A two-gram injection produces peak serum concentrations averaging about 100 mcg/ml at one hour with 15 mcg/ml at 8 hours. A four-gram injection produces peak serum concentrations averaging 160 mcg/ml at two hours with 31 mcg/ml at 8 hours.

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Book Review

Handbook of Obstetrics and Gynecology by Ralph C. Benson, M.D. Illustrated by Laurel V. Schaubert. Pp. 774. Price $6.50. Los Altos, Lange Medical Publications, 1971.

When I find a publication has gone through two or three editions, I am automatically impressed and think there must be a lot of good in it. In the case of this Handbook of Obstetrics and Gynecology, now in its fourth edition and available in Spanish and Portuguese, the generalization continues to stand. The author's purpose —"to present to the practicing physician and medical student a concise, current, and readily available digest of material for the accurate diagnosis and successful management of obstetric and gynecologic problems"—has been served. Who can ask for anything more?

The 774-page book has been divided a little unevenly into 17 chapters on obstetrics and 13 chapters on gynecology. The first section covers just about everything that DeLee and Greenhill do, but would like to emphasize the fact that this is a compact handbook to be used for quick reference rather than to be studied as a standard textbook. In addition to the usual subjects in the table of contents, one finds the chapter, Emotional Aspects of Pregnancy a good one for many of the younger men to read. A bonus in the gynecology section is a chapter on Medical Genetics, helping to clarify an extremely (at least, for me) complex subject.

The author touches here and there on topics not strictly obstetrical and gynecologic, but which certainly are useful to any practitioner. These topics are how to deal with cardiac arrest, management of the terminal cancer patient, leukemia, lymphoma, viral hepatitis, and others.

This volume—the Merck Manual of Obstetrics and Gynecology—is a must on the generalist's bookshelf.

Arthur Frederick Schiff, M.D.
Miami

Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

Lasers in Medicine by Leon Goldman, M.D. and R. James Rockwell Jr. Pp. 385. Illustrated. New York, Gordon and Breach, Science Publishers, Inc., 1971.

Current Concepts in Dyslexia edited by Jack Hartstein, B.S., M.D. Pp. 212. 34 Illustrations. Price $12. St. Louis, The C. V. Mosby Company, 1971.

Pathology, Sixth Edition, Volume One & Two, edited by W. A. D. Anderson, M.D. Pp. 1,901. 1,572 Illustrations. Price $29.50. St. Louis, The C. V. Mosby Company, 1971.

Pediatric Therapy, Fourth Edition, edited by Harry C. Shirkey, M.D. Pp. 1,221. 443 Illustrations. Price $34.50. St. Louis, The C. V. Mosby Company, 1972.

Approach to the Medical Care of the Sick Newborn by Sophie H. Pierog, M.D. and Angelo Ferrara, M.D. Pp. 292. 42 Illustrations. Price $11.50. St. Louis, The C. V. Mosby Company, 1971.

Biochemical Profiling in Diagnostic Medicine by Joseph A. Preston, M.D. and David B. Troxel, M.D. Pp. 51. Price $2.50 for set of five. Tarrytown, New York, Technicon Instruments Corporation, 1971.

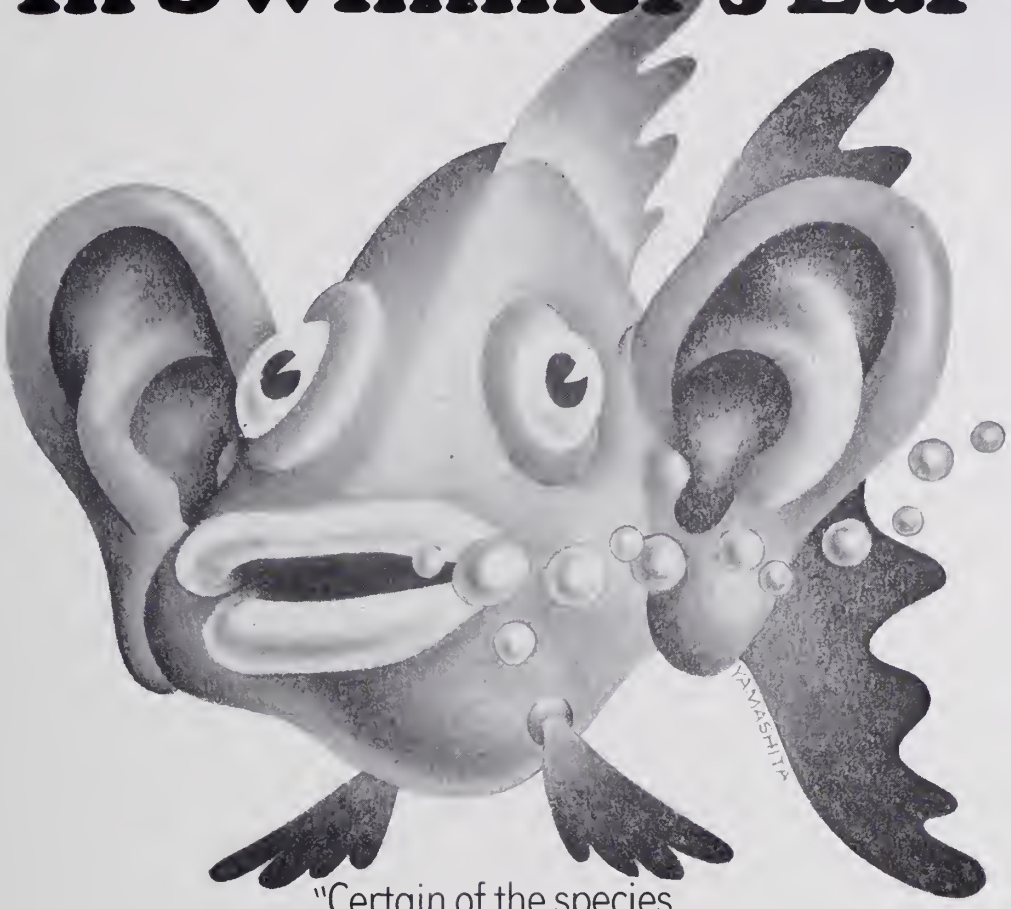
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FURACIN (nitrofurazone) and Micafur (nifuroxime) are active against a variety of gram-positive and gram-negative organisms. Activity versus Pseudomonas sp. is limited to certain strains. Micafur (nifuroxime) is active against Candida (Monilia) albicans.

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Blue Shield and Fiscal Intermediaries

Raymond J. Fitzpatrick, M.D.

Blue Cross of Florida, Inc., was 27 years old last year and Blue Shield of Florida was 25 years old. The Florida Hospital Association founded and sponsored Blue Cross and the Florida Medical Association founded and sponsored Blue Shield. Five years ago last year Blue Shield began administering the Medicare Part B program at the request of the Florida Medical Association.

Blue Cross and Blue Shield are distinct legal entities; separate institutions with separate Boards of Directors, fiscal structures and orientations—Blue Cross involved with hospitals, Blue Shield with doctors. They share computer services and some administrative personnel. Blue Shield is a member of the National Association of Blue Shield Plans for common administrative advantages but it is de facto and de jure separate from any other organization possessing in its title the words, Blue Shield.

As an institution ages it may lose rather than gain in stature unless its raison d'etre is recalled periodically. Blue Shield already existed when the majority of physicians here today entered practice. It was founded to assist patients with limited incomes to prepay by group action medical expenses that might on an individual basis prove financially devastating if not impossible to liquidate. Physicians sponsoring the establishment of Blue Shield were motivated both by altruism and self-interest. It was hoped that if low income persons who wished to be responsible citizens and not mere wards of the state could be helped to be self-sufficient in time of illness, that they would not seek assistance of the federal government who then, as now, was stertorously breathing down their necks to perform this service for them.

Such insurance provided the physician some fee return and the subscriber the good feeling, so nostalgically American, of standing on his own feet. For certain agreed upon low income levels, doctors signed a participating agreement to accept as payment in full whatever Blue Shield in its schedule of benefits would appropriately allow. Many believed the establishment of Blue plans throughout the nation was effective over the next two decades in forestalling the ultimate arrival of government medicine. How ironical then is history when that which was credited with forestalling government medicine has become the very instrument through which partial government medicine daily involves us. If it is historically true that the Blues did thwart the step by step logistical attack of the social planners, what better way for them to defeat us than from within? Perhaps the Blue Shield emblem in the future will require revision with Medicare depicted as the lion rampant upon the field of blue of its escutcheon. Will Medicare some day prove itself the Trojan horse of Blue Shield and American Medicare? I hope not.

Physician participation plus the nonprofit nature of Blue Shield made it unique compared to commercial insurance companies. Nonprofit meant less cost to the subscriber and increased benefits to his physician. Another unique feature of Blue Shield of Florida is constitution of its Board of Directors. The majority are practicing physicians elected by their fellow physicians at the annual meeting of the Florida Medical Association's House of Delegates.

As Blue Shield expanded and became more complex, it brought in its wake more problems in

Dr. Fitzpatrick is chairman of the Florida Medical Association's Committee on Advisory to Blue Shield and Fiscal Intermediaries.

Presented at the Fourteenth Annual Conference of County Medical Society Presidents and Secretaries, January 29, 1972, Orlando.

management. Fifteen years ago the Florida Medical Association appointed a committee of 17 physicians under the title Advisory to Blue Shield to act as liaison between physicians and Blue Shield. The committee's purpose was to help develop fee schedules, in some instances to adjudicate disputes between physicians and Blue Shield or between physicians and subscribers, and to develop socio-economic philosophies and guidelines as well as to serve in other advisory capacities.

Medicare

Until Medicare, a close working relationship existed between FMA and Blue Shield. They blazed trails in prepaid health insurance and in a pioneer spirit worked together, sweated together and succeeded together. But then the dragon Medicare raised its ugly head and fetidly spewed forth one unpalatable regulation after another, restricting the activities and liberties of those who tried to cooperate or coexist with it. Trying to placate a ruthless new mistress and handle efficiently almost four times as much budget as it ever had, Blue Shield hired more indians, created more chiefs, planned banks of computers and larger office buildings, with the result that the marriage between physicians and Blue Shield became at times quite strained even to the point of contemplated separation or divorce. The announcement that the Oklahoma State Medical Association had withdrawn endorsement of its state's Blue Shield plan should cause sober reflection on the part of physicians in Florida as well as Blue Shield. At the last FMA annual meeting the feelings of the House of Delegates with respect to Blue Shield were obviously ambivalent. In Resolution 71-19 the House was clearly condemnatory whereas in Resolution 71-13 it placatingly pledged its continued support and confidence. These times required sober reflection; not angry, hasty decisions.

We must somehow renew and strengthen that old feeling that Blue Shield truly supporting FMA and FMA supporting Blue Shield can play an important role in our dealings with the federal government. Those in FMA who would have Blue Shield resign as fiscal agent for Medicare must question who would do the job if Blue Shield did not. Medicare will not cease to be; it is the law of the land. If someone else acts as fiscal agent physicians would have to start over again in developing the working relationship that exists with the Blues. Somehow Blue Shield must be made to realize that its strength lies in steadfast physician support and not in the fickle arms of a capricious government. Blue Shield must be made to realize that without loyal physician militant might it will become a puppet on a string, a mere piper playing the tune as called by HEW.

Here then is a nonprofit insurance organization designed to pay physicians fees, sponsored by the Florida Medical Association with the majority of its Board of Directors elected by the House of Delegates, and a long history of Blue Shield—FMA cooperation. The FMA Committee, Advisory to Blue Shield and Fiscal Intermediaries is composed of 17 other doctors who act in your behalf. Through the 72 National Associations of Blue Shield Plans have we not an economic union if we would but use it wisely? If other states have 95% participation in Blue Shield as exists in this state, what a powerful political force this can represent if we would act in concert and perhaps with a bit of the same hauteur and arrogance shown by Washington.

Blue Shield acts as fiscal intermediary for the Medicare Part B program on a yearly renewable contract basis. Blue Shield claims financial soundness without Medicare and that its Medicare program is sequestered from the rest of its operation to permit, if ever required, easy amputation. Personally I doubt that Blue Shield would choose to disenfranchise itself from the government contract which has permitted it to truly become a giant. On the other hand, Medicare would find itself in a real bind if Blue Shield withdrew, especially national in scope. So long as doctors and government speak to each other through the medium of Blue Shield there still is hope, despite nit picking bureaucratic regulations to some degree of independence, for a good circle for boxing, sparring and footwork. If your independence as a physician truly knows no venal consideration, you are assured independence because you need not participate in the Medicare program. If you will participate then you must abide by government rules and regulations and fiats. The choice is yours individually and collectively. Do we "rather bear the ills we have than to fly to others we know not of?"

Participating Physicians

Blue Shield is far from perfect; so is each of us. If all participating physicians would participate in more than merely sharing fee benefits, a truly economic union for physicians could result.

With such a degree of participation, perhaps a medical foundation could be created for health care delivery that would permit us to retain some degree of independence as we become by government fiat involved in Washington's concept of adequate health care delivery. If physicians are to retain control of peer review and utilization, computer hardware will be needed for this purpose. We do not have it but Blue Shield does. This is the way it can be.

At present I find it most difficult as a physician to hold my head high when abused by a government that arbitrarily and unilaterally and without more vigorous opposition on our part:

Lowers the percentile of payment at a whim.

Refuses to change the wording that has become a thorn in our side, "Beyond allowable charges."

Permits the patient on presentation of an unreceipted unassigned claim to receive payment.

Refuses to notify physicians when payment is made to patient.

Uses in profiles yesteryears figures to pay this years bills.

Demands during the wage freeze that physicians prove the need to increase fees by 2.5% whereas others may increase charges without proof of need.

So reduces Blue Shield's request for rate increases in the new FEP contract that lost millions last year for Blue Shield plans throughout the country; so reduces rate increases that as Blue Shield accepts this year it wonders whether more millions will be lost before it must walk away from the program.

These are some of the things that need changing. Blue Shield has truly tried on some but to no avail. If FMA and Blue Shield were more earnestly and vigorously united could they bring about change that their present lacklustre efforts have failed to achieve?

Let us then as physicians be understanding at this very critical time in American Medicine of what FMA is trying to do for each of us. Keep a close watch on those physicians you elect to the Board of Directors of Blue Shield to represent your interests. The physician members of the Board do not have to do what you or FMA might want them to do. But in general I think that many times they would like to see new or increased benefits provided by Blue Shield as demanded by their fellow physicians. They are often hampered in so acquiescing by insurance rules and regulations laid down by the state that issued the corporate charter. At other times they are hampered by ill-conceived, illogical, intransigent, invidious Social Security Administration Mickey Mouse bureaucratic nonsense. At times also they may reject matters based upon instructions from nonphysician Board members or Blue Shield staff that this or that item might be economically or otherwise unachievable or fiscally reckless for Blue Shield. So, while you cannot make the physicians you elect to the Board act in any certain direction, you can certainly let them know your views before and after some action is taken.

Hold them accountable one way or the other. Make them keep you informed as you inform them of what is disturbing you. Make your problems and gripes known also to the Committee of Seventeen. Try us, you'll like us. But be patient and understanding, realizing that it takes time to set up committee meetings and get your problems on the conveyor belt that is part of the democratic system of committees to councils to Board of Governors to ultimate final action. And keep a talley sheet to see that what you asked to be looked into has been accomplished. Instead of carping at Blue Shield for whatever reason, sit down and write the complaint to some doctor on the Blue Shield Board, Committee of Seventeen or FMA. Why be selfish and keep those brilliant ideas to yourself? You may have the very answer we are all struggling to find. As the kids say, "Let's get it all together, man!"

▶ Dr. Fitzpatrick, 706 Southwest 4th Avenue, Gainesville 32601.



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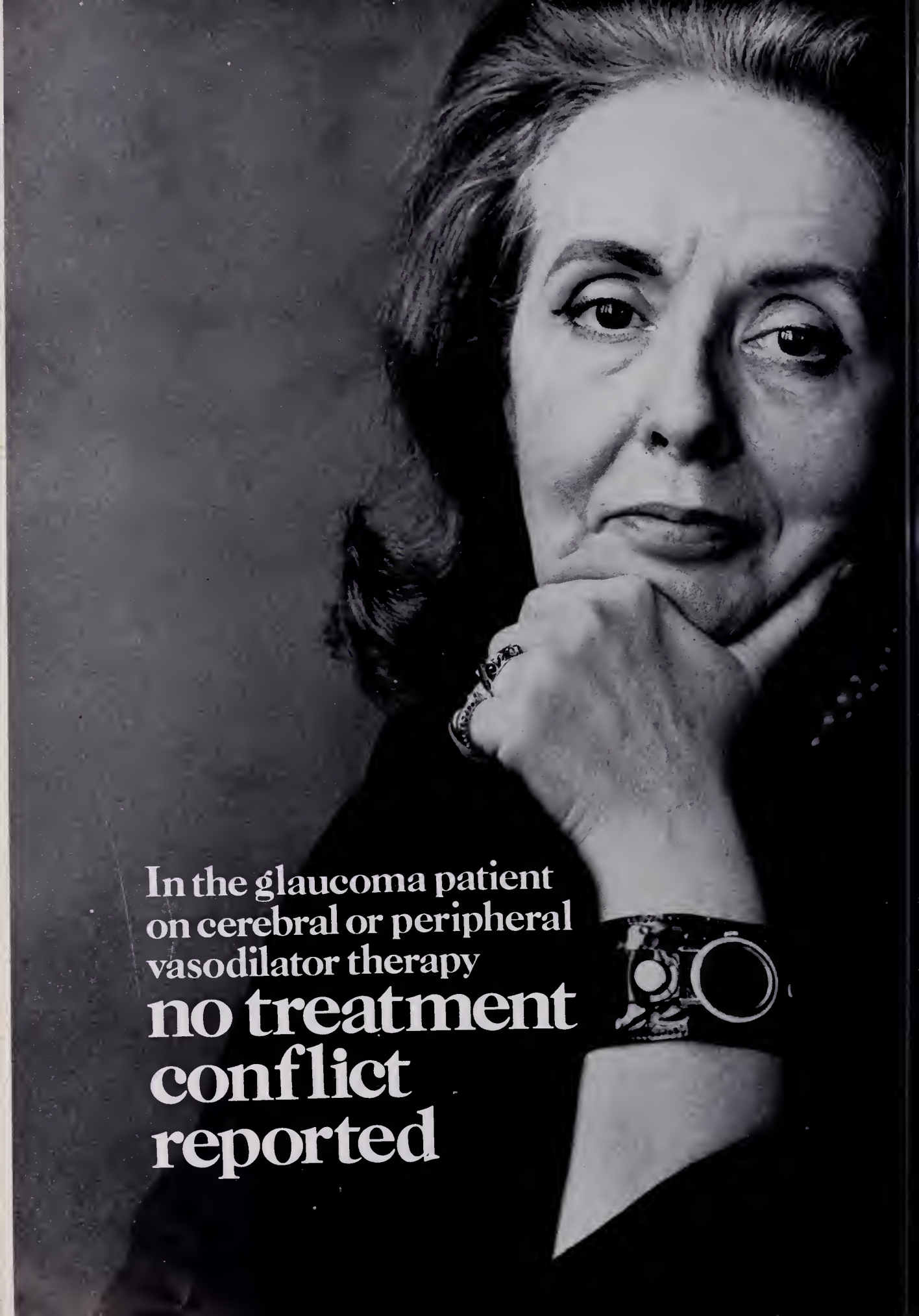
As the "middle years" exact their metabolic toll, complaints are vague, but therapy can be specific.
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ACTION AND USES—*DOSAGE:* 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. *PRECAUTIONS:* Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. *CONTRAINDICATIONS:* Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. *AVAILABLE:* Bottles of 30, 100, and 500 tablets.

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In fact, there are no known contraindications in recommended oral doses other than it should not be given in the presence of frank arterial bleeding or immediately postpartum.

Although not all clinicians agree on the value of vasodilators in vascular disease, several investigators[1-4] have reported favorably on the effects of isoxsuprine. Effects have been demonstrated both by objective measurement[2,4] and observation of clinical improvement.[1-4]

Indications: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). Composition: VASODĪLAN tablets, isoxsuprine HCl 10 mg and 20 mg. Dosage: Oral—10 to 20 mg. t.i.d. or q.i.d. Contraindications and Cautions: There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of arterial bleeding. Side Effects: Occasional palpitation and dizziness can usually be controlled by dosage reduction. Complete detail available in product brochure from Mead Johnson Laboratories. References: 1. Clarkson, I. S., and LePere, D. M.: Angiology *11*:190-192 (June) 1960. 2. Horton, G. E. and Johnson, P. C., Jr.: Angiology *15*:70-74 (Feb.) 1964. 3. Dhrymiotis, A. D., and Whittier, J. R.: Curr. Ther. Res. *4*:124-128 (April) 1962. 4. Whittier, J. R.: Angiology *15*:82-87 (Feb.) 1964.

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Description: CANDEPTIN (candicidin) Vaginal Ointment contains a dispersion of candicidin powder equivalent to 0.6 mg. per gm. or 0.06% Candicidin activity in U.S.P. petrolatum. 3 mg. of Candicidin is contained in 5 gm. of ointment or one applicatorful. CANDEPTIN Vaginal Tablets contain Candicidin powder equivalent to 3 mg. (0.3%) Candicidin activity dispersed in starch, lactose and magnesium stearate. CANDEPTIN VAGELETTES Vaginal Capsules contain 3 mg. of Candicidin activity dispersed in 5 gm. U.S.P. petrolatum.
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Indications: Vaginitis due to Candida albicans and other Candida species.
Contraindications: Contraindicated for patients known to be sensitive to any of its components. During pregnancy manual Tablet or VAGELETTES Capsule insertion may be preferred since the use of the ointment applicator or tablet inserter may be contraindicated.
Caution: During treatment it is recommended that the patient refrain from sexual intercourse or the husband wear a condom to avoid re-infection.
Adverse Reaction: Clinical reports of sensitization or temporary irritation with CANDEPTIN Vaginal Ointment, Vaginal Tablets or VAGELETTES Vaginal Capsules have been extremely rare.
Dosage: One vaginal applicatorful of CANDEPTIN Ointment or one Vaginal Tablet or one VAGELETTES Vaginal Capsule is inserted high in the vagina twice a day, in the morning and at bedtime, for 14 days. Treatment may be repeated if symptoms persist or reappear.
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Store under refrigeration to insure full potency.

Federal law prohibits dispensing without prescription.

References: **1.** Olsen, J.R.: Journal-Lancet *85* 287 (July) 1965. **2.** Giorlando, S.W.: Ob/Gyn Dig. *13*:32 (Sept.) 1971. **3.** Decker, A.: Case Reports on File, Medical Department Julius Schmid. **4.** Giorlando, S.W., Torres, J.F., and Muscillo, G.: Am. J. Obst. & Gynec. *90*: 370 (Oct. 1) 1964. **5.** Lechevalier, H.: Antibiotics Annual 1959-1960. New York, Antibiotica Inc., 1960. pp. 614-618. **6.** Friedel, H.J.: Maryland M.J., *15*:36 (Feb.) 1966.

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Medical News

Central Florida Society of Ophthalmology Meet in Orlando

The Central Florida Society of Ophthalmology will hold its first annual spring meeting at the Contemporary Hotel, Disney World, on Saturday, April 29, 1972. The guest speakers will be Doctor A. Edward Maumenee, Director of the Wilmer Institute, Baltimore, and Doctor Arthur Jampolsky, Director of the Smith-Kettlewell Institute of Visual Sciences, San Francisco. Doctor Maumenee will speak on "Macular Diseases." Doctor Jampolsky will speak on "Restrictive Strabismus Problems," and, "Horizontal Strabismus Surgery." Registration fee $20. For information write: William Z. Bridges, M.D., 451 Park Ave., N., Winter Park, Florida 32789.

Cancer Center in Miami

A modern facility for cancer treatment has been unveiled at Jackson Memorial Hospital in Miami.

The center, which cost more than $1.1 million, will be used by the hospital's Department of Radiology and the University of Miami School of Medicine and was funded by the Dade County Department of Hospitals and the School of Medicine.

Dr. Taylor Is Installed

Jape Taylor, M.D., of Gainesville, has been installed as President of the Southern Society for Clinical Investigation. Dr. Taylor, Professor and Chief of Cardiology at the University of Florida College of Medicine, is a former President of the Florida Heart Association.

New Medical School Gets Grant

A federal grant of $7,485,708 has been earmarked for the University of South Florida College of Medicine at Tampa.

The funds will be applied to construction of a basic science building at the new medical school. The grant was made available through the Division of Physician and Health Professions Education of the National Institutes of Health.

Hill-Burton Grant

A $225,000 Hill-Burton construction grant has been approved in Washington for the University of Florida's Shands Teaching Hospital and Clinics in Gainesville.

The funds will be applied toward construction of a second floor to the outpatient wing. The addition, necessitated by a rapidly growing ambulatory care program, is expected to cost about $460,000.

New ACA Fellow

Algia B. Collins, M.D., of Fort Myers, has been certified as a Fellow of the American College of Anesthesiologists.

Orthopaedic Fellows

Two Florida physicians were inducted as Fellows of the American Academy of Orthopaedic Surgeons during the Academy's annual meeting in Washington, D.C., recently. They are Dermot J. O'Conner, M.D., of St. Petersburg and Patrick J. Logue, M.D., of Clearwater.

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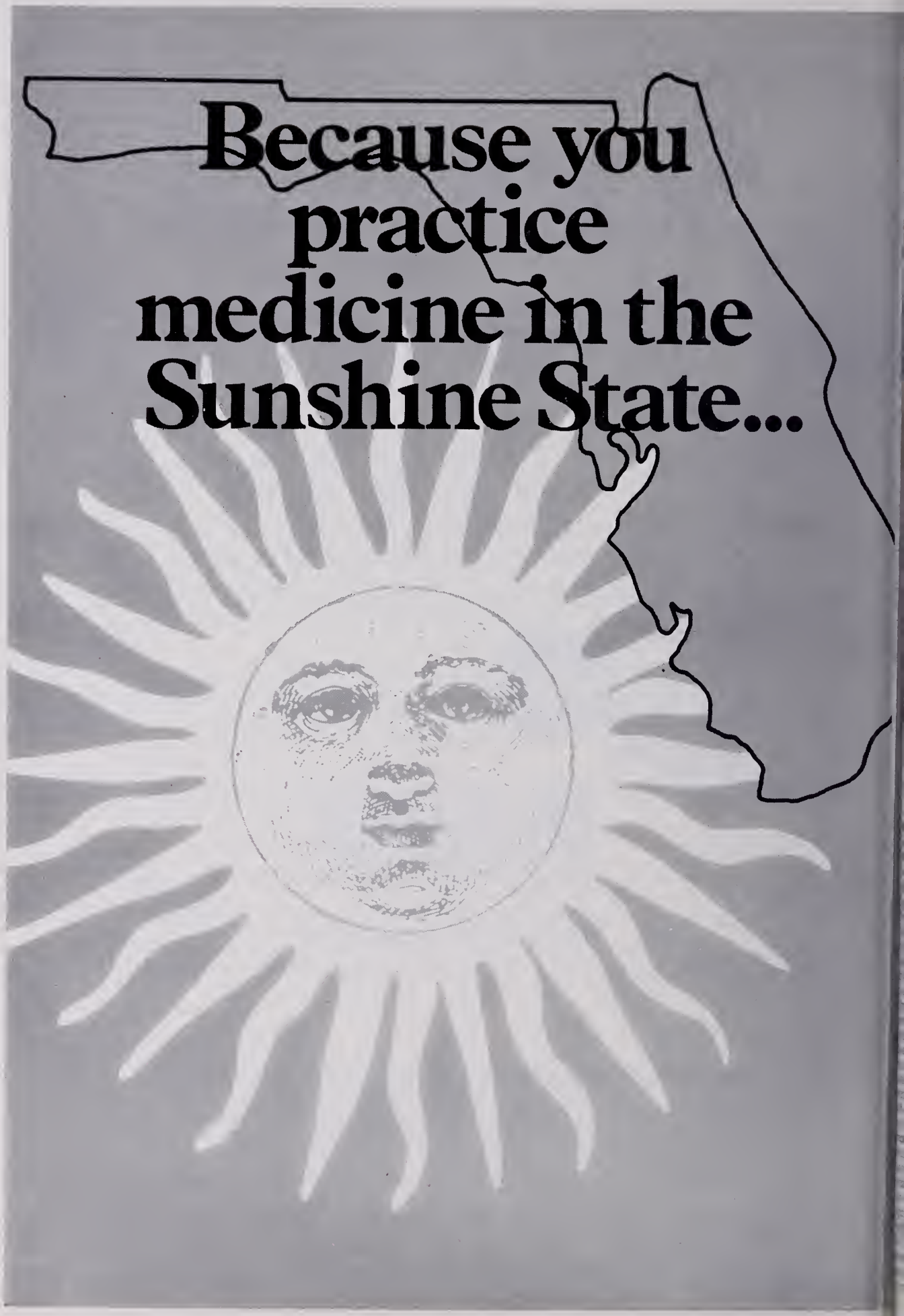
Tablets 15 mg., 30 mg.
Elixir 30 mg./5 cc. (alcohol 7%)

Indications: Useful as a daytime sedative when mild sedation is required for relief of symptoms of anxiety or tension resulting from emotional, physical, or situational stress.
Contraindications: Porphyria or sensitivity to barbiturates. **Warning:** May be habit forming.
Precautions: Exercise caution in moderate to severe hepatic disease. Elderly or debilitated patients may react with marked excitement or depression. **Adverse Reactions:** Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and systemic disturbances are seldom seen.
Usual Adult Dosage: For daytime sedation, 15 mg. to 30 mg. t.i.d. or q.i.d.
Also available: BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg., 30 mg.,

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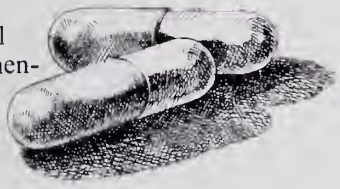
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For optimal response, dosage can be adjusted to suit patient needs—1 or 2 capsules, 3 or 4 times a day.

To help relieve anxiety-linked symptoms in gastritis and duodenitis

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Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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MEETINGS

Approved by FMA Committee on Continuing Education

APRIL

14 Hyperlipidemia by Jacksonville Hospitals Educational Program, Thunderbird Motel, Jacksonville. For information: IHEP, 2000 Jefferson St., Jacksonville 32206.

15 Sixth Annual Medical Seminar for Physicians, Sheraton Bel Aire, St. Petersburg. For information: American Cancer Society, Florida Division, 1001 S. MacDill Ave., Tampa 33609.

MAY

11-13 Twenty-Second Annual Seminar "Current Concepts in Diagnosis and Therapy," Mt. Sinai Hospital, Miami Beach. For information: Frances Richardson, Mt. Sinai Hospital, 4300 Alton Rd., Miami Beach 33140.

JUNE

5-10 Sixth Annual Workshop in Electrocardiography, Tides Bath Club, Redington Beach. For information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg, Florida 33705.

12-17 Course of Instruction in Coronary Care for the Practicing Physician, Jackson Memorial Hospital, Miami. For information: Louis Lemberg, M.D., U. of Miami School of Medicine, Box 875, Biscayne Annex, Miami 33152.

Florida State Board of Medical Examiners:
July 23-25, 1972, Miami Beach

For information: Mrs. Marjoriann Keebler, Administrative Assistant, Florida State Board of Medical Examiners, 2717 E. Oakland Pk. Blvd., Fort Lauderdale, Fla. 33306.

National and Regional Meetings Held in Florida

APRIL

24-28 Association for Research in Vision and Ophthalmology, Sheraton Sandcastle, Sarasota. Sec.-Treas.: Robert D. Reinecke, M.D., Dept. of Ophthalmology, Albany Medical College, Albany, N.Y. 12208.

MAY

8-11 Aerospace Medical Association, Americana Hotel, Miami Beach, Ex. V.P., Merrill H. Goodwin, M.D., Washington National Airport, Washington, D. C. 20001.

14-19 American Radium Society, James Ewing Society, and Society of Head and Neck Surgeons, (joint meeting), Boca Raton. Victor D. Dembrow, M.D., Chm., Local Arrangements, 1150 Northwest 14th Street, Miami 33136.

20-27 American Society for Anesthetic Plastic Surgery, Caribbean Cruise, Miami. Sec.-Treas.: Simon Fredricks, M.D., 1103 Medical Towers, Houston, Texas 77025.

NOVEMBER

2- 4 International Conference on Trichinellosis, Sheraton-Four Ambassadors Hotel, Miami. Sec.: W. C. Campbell, Ph.D., Merck Institute, Rahway, N. J. 07065.

2- 6 Association of American Medical Colleges, Fontainebleau Hotel, Miami Beach. Pres.: John A. D. Cooper, M.D., 1 Dupont Circle, Washington, D. C. 20036.

6-10 American Society of Tropical Medicine and Hygiene, Deauville Hotel, Miami Beach. Sec.-Treas.: George R. Healy, Ph.D., P.O. Box 15208, Emory University Branch, Atlanta, Ga. 30333.

19-22 Pan American Medical Association, Deauville Hotel, Miami Beach. Dir. Gen.: Joseph J. Eller, M.D., 745 5th Avenue, New York 10022.

Interested in a Working Vacation Abroad?

Some of the major organizations sponsoring volunteer physicians abroad are listed here for the benefit of Florida physicians wishing to spend vacations in other countries where their medical knowledge and help are needed. Interested physicians should contact directly the sponsoring organization of their choice for further information.

- **Volunteer Physicians for Viet Nam,** 535 North Dearborn St., Chicago, Ill. 60610.
- **Project HOPE,** The People-to-People Health Foundation, Inc., 2233 Wisconsin Ave., Washington, D.C. 20007.
- **AmDoc, Inc.,** 27 E. Cannon Perdido St., Santa Barbara, Calif. 93101.
- **FOCUS, Inc.** (Ophthalmologists), 1431 Ashland Ave., River Forest, Ill. 60305.
- **Project Concern, Inc.,** P.O. Box 2468, San Diego, Calif. 92112.
- **Medical Assistance Programs, Inc.,** Box 50, Wheaton, Ill. 60187.
- **Catholic Medical Mission Board,** 10 W. 17th St., New York 10011.
- **Christian Medical Council for Overseas Work,** National Council of the Churches of Christ in the USA, 475 Riverside Dr., New York 10027.
- **World Brotherhood Exchanged,** Lutheran Council in the USA, 315 Park Ave. S., New York 10010.
- **Operation Crossroads Africa, Inc.,** 150 Fifth Ave., New York 10011.
- **MEDICO,** Orthopaedics Overseas Division, 2007 Eve St., NW, Washington, D.C. 20006.
- **Holidays for Humanity, Inc.,** 3700 Bellemeade Ave., Suite 105, Evansville, Ind. 47715.

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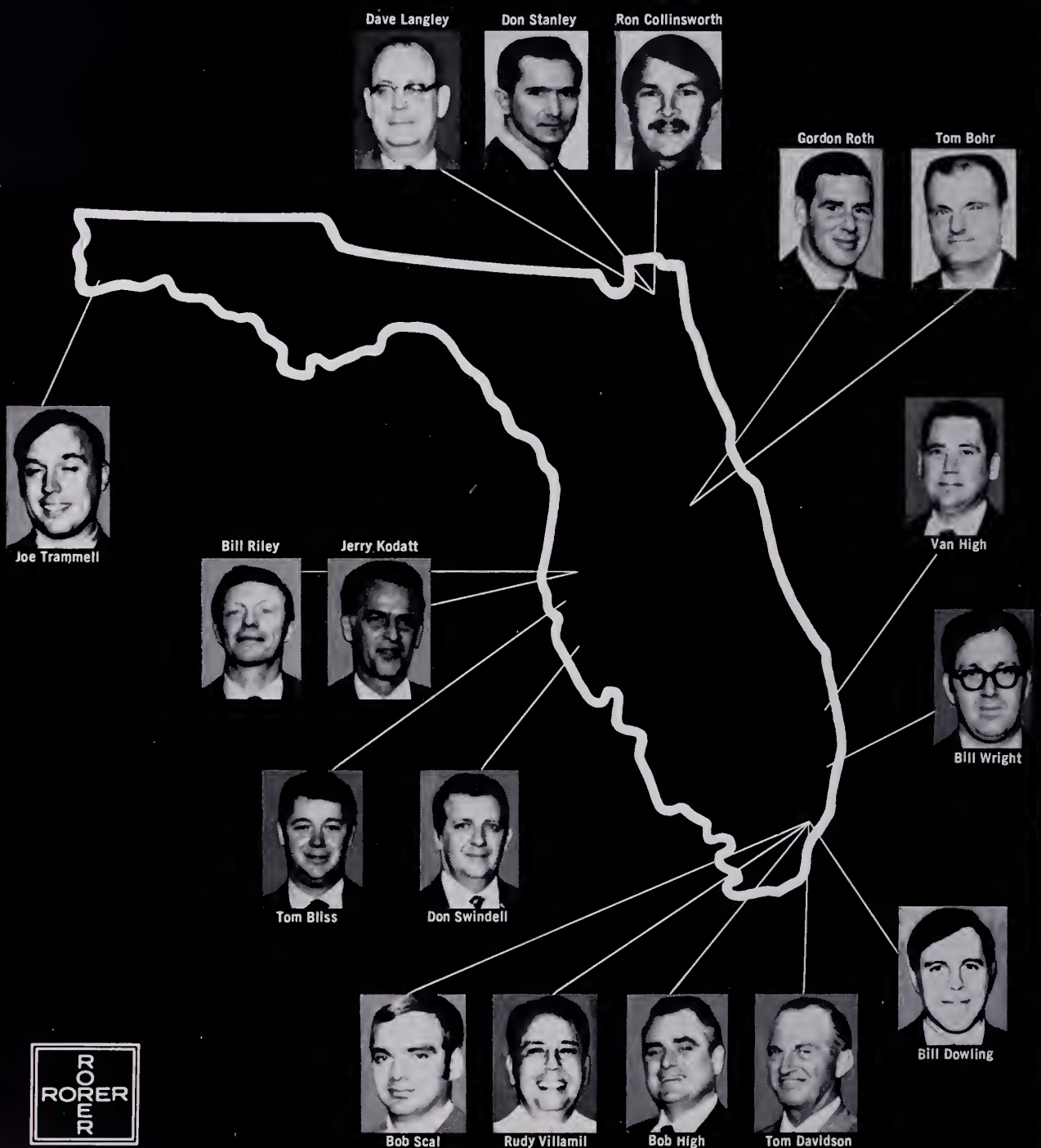
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WANTED: ASSOCIATE FOR FAMILY PRACTITIONER in Fort Lauderdale area. Age 34. Florida license required. No obstetrics or major surgery. Financial arrangements open. Send resume to C-530, P.O. Box 2411, Jacksonville, Florida 32203.

FAMILY PHYSICIAN AND INTERNIST WANTED: To join specialty group in rapidly growing area. Salary and partnership negotiable. Excellent 450-bed new hospital. Contact James Morgan, M.D., 400 Avenue "K," S.E., Winter Haven, Florida 33880.

WANTED: Family physician, internist to join established group in one of fastest growing areas of nation on Florida West coast. Group now consists of diplomate ABFP, board surgeon, board eligible surgeon and 2 family physicians who are AOA. Above average guarantee against gross. 46-week year. Call or write or visit James M. Marlowe, M.D., P.O. Box 1058, New Port Richey, Florida 33552. Phone (813) 849-2238.

GENERAL PRACTITIONER OR INTERNIST to associate with busy established medical doctor. Clinic type building, x-ray and full laboratory. Salary first year, then partnership. Rapidly growing area on Gulf Coast. Contact M. J. Hetman, M.D., Beach Medical Clinic, Fort Myers Beach, Florida 33931.

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INTERNIST, UROLOGIST, GP's.: Outstanding opportunities in progressive nonurban community serving 20,000. Write John H. Parker, M.D., Chief of Staff, Doctors Memorial Hospital, Perry, Florida 32347.

INTERNIST WANTED: For association, greater Miami area, Please send curriculum vitae to C-524, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST: Board certified or qualified, internal medicine, to join four other internists. Salary first year; percentage and partnership to follow. Write or call Pompano Medical Group, 2480 Northeast 23rd Street, Pompano Beach, Florida 33062. Telephone (305) 942-0100.

INTERNIST: To join group of three doing General Medicine; Incorporated; Laboratory on premises. Salary initially $3,000 monthly to lead to full partnership; equality of scheduled time off. Write C-534, P.O. Box 2411, Jacksonville, Florida 32203.

OPHTHALMOLOGIST, Board certified or qualified. Must have adequate retinal surgery training. South Florida city. Excellent opportunity. Write C-535, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST WANTED: Board eligible or certified, preferably with subspecialty, interest in hematology and/or gastroenterology to join flourishing practice in Fort Lauderdale area. Excellent salary and fringe benefits first year, leading to association. Must have Florida license. Please phone (305) 565-6434.

INTERNIST AND/OR GENERAL PRACTITIONER WANTED: To associate with general surgeon and Ob-Gyn partnership in Central Florida small town near Disney World and near new Barnum Bailey enterprise. Adequate salary first year—partnership second year. Send particulars to C-539, P.O. Box 2411, Jacksonville, Florida 32203.

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INTERNIST WANTED: Specialty open; join partnership of three internists in Hollywood. One year salary, then partnership. Write C-540, P. O. Box 2411, Jacksonville, Florida 32203.

CHIEF PATHOLOGIST WANTED: For 520 bed accredited community hospital in Hollywood, Florida. Write Dr. Marvin S. Allen, Chief of Staff, Memorial Hospital, 3501 Johnson Street.

WANTED: Urologist, Ob-Gyn, Internist, orthopaedist to join expanding group of young, well qualified family physicians and surgeons now consisting of diplomate ABFP, board certified surgeon, board eligible surgeon and 2 family physicians who are AOA. Service area of about 80,000 served by 10 M.D.s; one of fastest growing in entire nation. Two hospitals with open staffs. Additional office space soon available. Above average guarantee against gross. 46-week year. Call or write or visit James M. Marlowe, M.D., P.O. Box 1058, New Port Richey, Florida 33552. Phone (813) 849-2238.

ADDITIONAL PHYSICIANS URGENTLY NEEDED: GP, internal medicine, obstetrics, pediatrics, and general surgery. Modern office immediately available. Contact I. B. Price, M.D., P.O. Box 819, Quincy, Florida 32351.

Miscellaneous

PHYSICIANS WANTED IN FLORIDA, DIVISION OF MENTAL HEALTH: Positions are available for qualified physicians (Florida license not required). General practitioners, internists, surgeons, psychiatrists—in the hospital facilities of the Division of Mental Health. Interest, accompanied by a curriculum vitae, should be directed to E. Arthur Larson, M.D., Deputy Director for Hospitals and Institutes, Division of Mental Health, 200 East Gaines Street, Room 425, Tallahassee, Florida 32304.

WANTED IMMEDIATELY: Private emergency room physician. Corporate group needs fifth physician in teaching hospital, Orlando, Florida. Prefer GP. Florida license required. Contact Bruce S. Webster, M.D. (305) 647-5728 or Robert Gay, M.D. (305) 422-0159.

PHYSICIANS NEEDED: Tallahassee, Leon County, Northwest. General practitioners, internists and pediatricians in particular. Inquiries regarding practice in this community can be forwarded to J. Orson Smith Jr., M.D., Chairman, Physician Procurement Committee, 1433 Miccosukee Rd., Tallahassee, Fla. 32303. Phone (904) 877-1145.

DUNEDIN, Pinellas County, middle west coast, Clearwater area. Thirty-six physician multispecialty group seeking internist-gastroenterologist, neurologist, pathologist, obstetrician-gynecologist, GP, and emergency room physician. Affiliated general hospital just expanded to 308 beds. Clinic expansion to be completed January 1972. Long range plans for 650 beds and 75-physician clinic. No investment required. Contact Donald M. Schroder, administrator, Mease Hospital and Clinic, P.O. Box 760, Dunedin 33528, phone (813) 733-1111.

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URGENT NEED FOR INTERNIST, PEDIATRICIAN, EMERGENCY ROOM PHYSICIAN, AND TWO GP'S. Extremely attractive financial arrangement available. Must have Florida license. Outstanding opportunity in expanding group practice in modern clinic, lower West Coast. Gracious community of 32,000 in the heart of Florida's last water frontier. Excellent schools, shopping, golf, tennis, fishing and water sports. Contact: Director, Charlotte Inter-Medic Health Center, 1120 South Tamiami Drive, Port Charlotte, Florida 33950. Telephone: (813) 629-7501.

M.D.'s NEEDED in Palm Beach County. Ideal for retired, semi-retired or newly established to supplement income. No investment. Florida license required. Write to A. Ginsburg, M.D., 10475 Riverside Drive, Palm Beach Gardens, Florida 33403, or call (305) 622-0800.

CENTRAL FLORIDA AREA: Lovely residential community just above Orlando and Disney World. Many lakes, water activities, and growing family living area! Excellent opportunity for one or two associates in unique, brand new medical center for family practice with OB; surgical privileges if desired at nearby modern 155-bed hospital. Florida license necessary and residency preferred. Initially, no expenses with guaranteed minimum plus percentage. Contact Randall B. Whitney, M.D., 1100 Morningside, Mount Dora, Florida 32757. Phone (904) 383-6129.

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YOUNG ANESTHESIOLOGIST: Fully university trained—wide experience. Board certified, military complete, Florida license, wants busy location. Write C-536, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST: Board eligible, Age 31. Subspecialty endocrinology plus one year cardiology fellowship. Former chief resident, university trained, completed military obligations, Florida licensed. Would like to join group practice or partnership in internal medicine. Would prefer teaching appointment at community hospital combined with private practice available. Write C-532, P.O. Box 2411, Jacksonville, Florida 32203.

AMERICAN PHYSICIAN, age 64, general medicine, Ohio license, desires part time work in vicinity of Palm Beach. Write C-537, P.O. Box 2411, Jacksonville, Florida 32203.

PEDIATRICIAN, Board eligible, 30 years old, university trained, military completed, Florida license, seeking to join with other pediatricians near major metropolitan area. Contact: Barry Levy, M.D., 7777 Southwest 86th Street, Miami, Florida 33143.

OBSTETRICIAN-GYNECOLOGIST: Board certified, military obligations completed. Wishes Southeast or Southwest Florida coastal area. Primarily interested in a multi-specialty group. Have Florida license and currently available. Contact John K. Schanze, M.D., 3631 White Sulphur Place, Sarasota, Florida 33580 or call (813) 922-7591 or (813) 955-4702.

RADIATION THERAPIST: Department head, age 40, with Florida license wants to relocate in warm coastal area. Write C-542, P.O. Box 2411, Jacksonville, Florida 32203.

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LEASING PRIVATE SUITES: Orlando-residential area near new hospital needs GP or pediatrician. Completed one story medical building—trees, staff parking, rear entrance, ready now. Contact Marcus O. Williams, D.M.D., 201 Maitland Ave., Altamonte Springs, Florida 32701.

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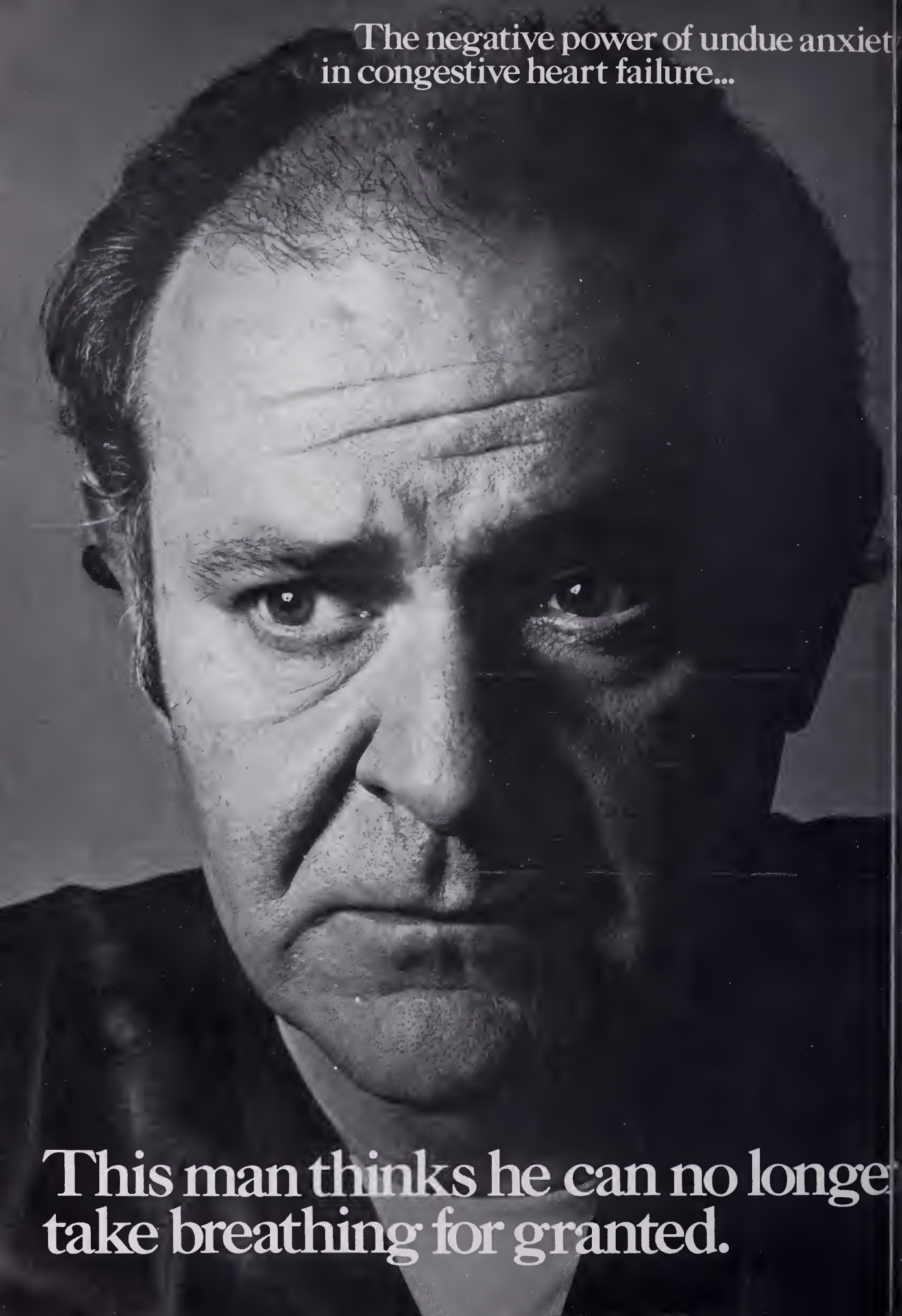
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

VOL. 59, NO. 5

MAY 1972


The negative power of undue anxiet
in congestive heart failure...
This man thinks he can no longe
take breathing for granted.

Typical of many patients with congestive heart failure, he also suffers from severe anxiety, a psychic factor that may influence the character and degree of his symptoms, such as dyspnea. His apprehension may also deprive him of the emotional calm so important in maintenance therapy.

Aid in rehabilitation

pecific medical and environmental measres are often enhanced by the antianxiety ction of adjunctive Libritabs (chlordiazoxide). Libritabs can also facilitate treatent of the tense convalescent patient until ntianxiety therapy is no longer required. Whereas in geriatrics the *usual daily dosage* 5 mg two to four times daily, the *initial osage* in elderly and debilitated patients ould be limited to 10 mg or less per day, djusting as needed and tolerated.

Concomitant use with primary agents

ibritabs is used concomitantly with certain ecific medications of other classes of rugs, such as cardiac glycosides, diuretics, ntihypertensives, vasodilators and oral nticoagulants, whenever excessive anxiety emotional tension adversely affects the inical condition or response to therapy. lthough clinical studies have not estabshed a cause and effect relationship, phycians should be aware that variable effects n blood coagulation have been reported ery rarely in patients receiving oral antiagulants and chlordiazepoxide HCl.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

The positive power of Libritabs®

(chlordiazepoxide)

5-mg, 10-mg, 25-mg tablets

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up to 100 mg daily

for severe anxiety accompanying ongestive heart failure

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JFMA

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Troy H. Hutchinson, M.D. *Otolaryngology*
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Willard H. Martz, M.D. *Dermatology*
Eugene L. Nagel, M.D. *Anesthesiology*
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Harry W. Reinstine, M.D. *Surgery*
David H. Reynolds, M.D. *Neurosurgery*
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Gerold L. Schiebler, M.D. *Pediatrics*
Frank J. Seidl, M.D. *Phys. Med. & Rehab.*
Donn L. Smith, M.D. *U. of South Florida*
F. Norman Vickers, M.D. *Internal Medicine*
Clyde M. Williams Jr., M.D. *U. of Florida*
S. Russell Wilson, M.D. *Neurology*
J. B. Williams Jr., M.D. *Obstetrics-Gynecology*

This Issue

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MAY COVER—Florida's proud heritage—the Sand, the Sea, the Seagull and the beautiful Palm Trees.

President's Page



The National Health Insurance Plan

On the President's Page for June 1970, Dr. James Cook discussed the alternatives to government medicine, and lamented the fact that it would be most difficult to attempt to convince the American public and Congress that federal intervention is not the solution to the problem of medical care.

Two years later the question is not whether the federal government will or will not develop a program, but which program they will use. At a luncheon with our Congressional delegation on March 13, the officers and key contact physicians of the State learned first hand of some of the proposals which are pending; but most important, we learned of the significance of Representative Wilbur Mills' speech in Atlanta before the Second National House Staff Conference.

In this speech Congressman Mills indicated his preference to include: 1.—An overhaul of Medicaid for the poor, relieving the states of their share of financing and utilizing the insurance industry for administration; 2.—Financing the program by requiring employers to participate in the payment of nongovernment health insurance for their employees, and 3.—To establish the Federal Catastrophic Protection Program to become operative if the basic health insurance is exhausted. This plan closely follows and parallels the AMA's Medicredit Plan, and we of the Florida Medical Association would favor amending the Medicredit proposal to conform with the ideas of Congressman Mills. It was Mr. Mills' opinion that the government can provide, "the mechanism under which virtually every American family, regardless of its situation, will have the same coverage at about the same price, and I believe we can do it without having to place on the federal bureaucracy the entirely impossible administrative task of managing our entire health complex."

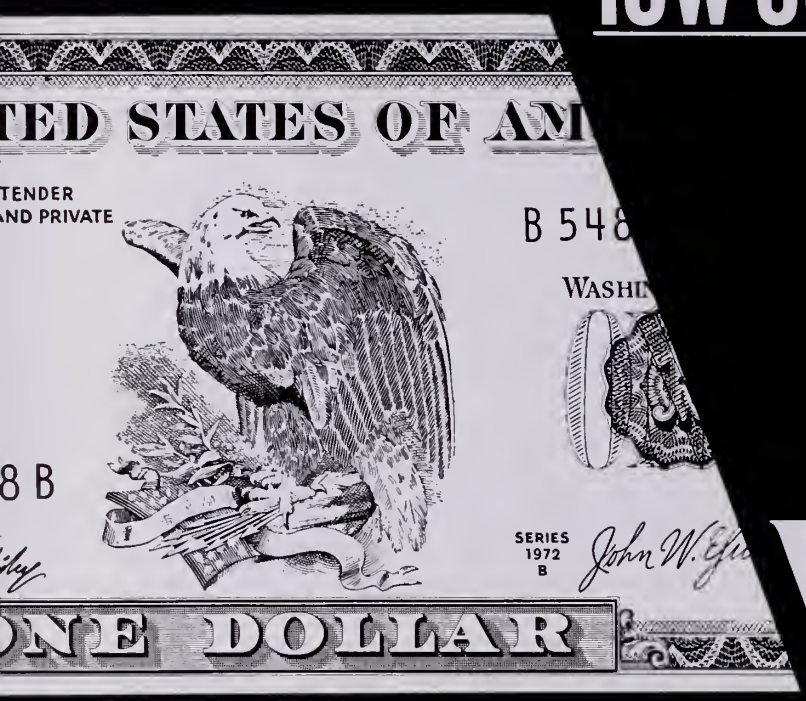
No matter what kind of a national health bill is finalized, Representative Mills asserted, "the impetus for real and lasting change in our health system must come largely from those working within the system." To me, this indicates that his committee at least, if not others are willing to discuss the many problems confronting the magnitude of the plan that he has in mind. I believe that when the opportunity arises that we, through the organization of the FMA and the AMA, must see that we have a health care delivery system which can serve the people of our nation—and perhaps be a model for the entire world.

There are other clouds on the horizon, however, which we must keep a wary eye upon. Number one is the Health Maintenance Organization concept which is being pushed by both Senator Kennedy and the Administration, calling for a several billion dollar commitment to subsidize prepaid group or contract practices as a new way of delivering health care. The other is the Professional Standards Review Organization, which, as has been outlined, will prove most difficult for physicians to work with and will eventually be of very little benefit as far as elevating the quality of medical care.

Representative Mills indicates that the lack of sufficient time before the political party conventions will prevent his committee from concluding the consideration and formulation of any substantial health legislation in 1972, but let us beware of the changes which will follow in 1973.

J. K. Hurst M.D.

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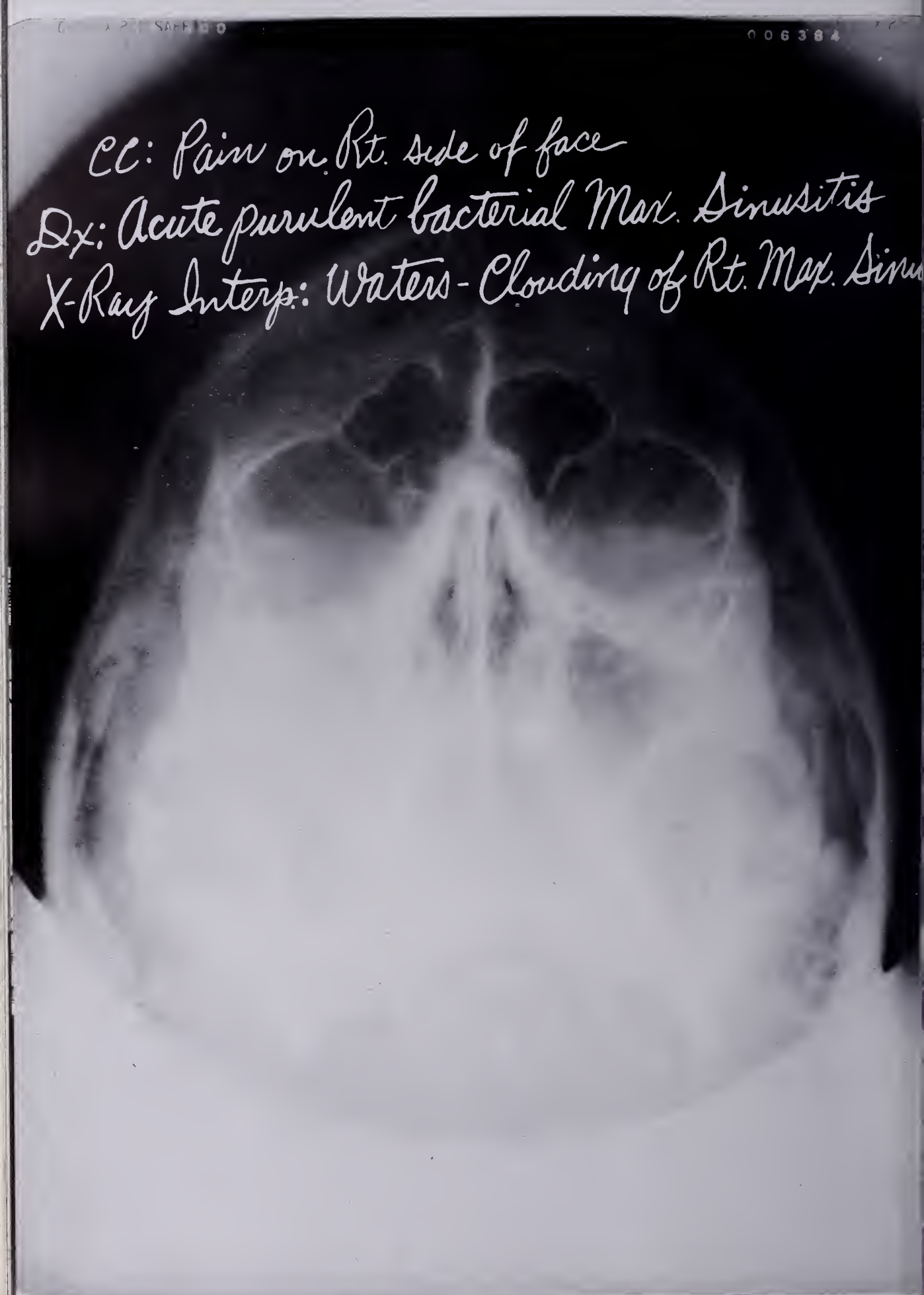
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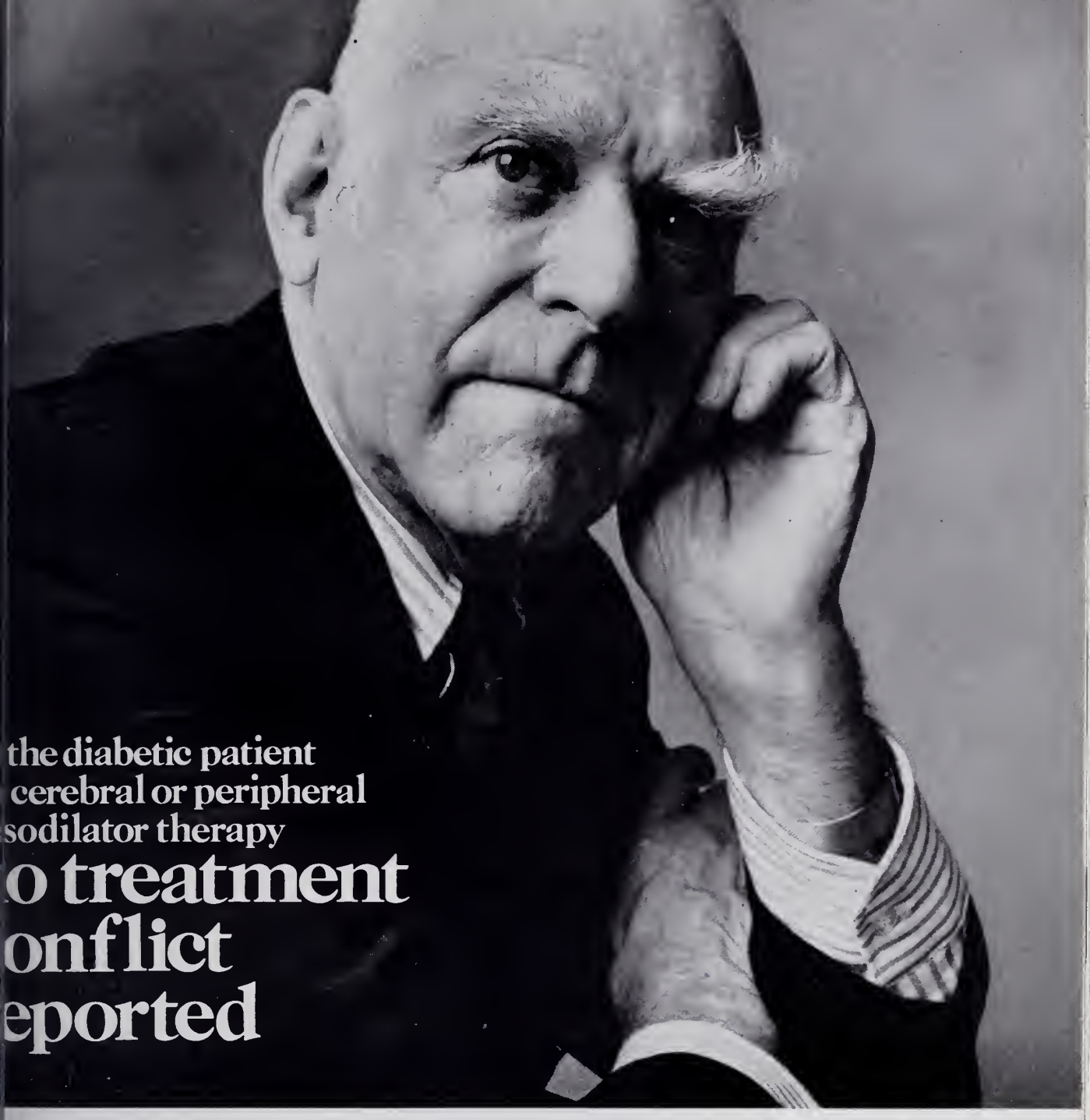
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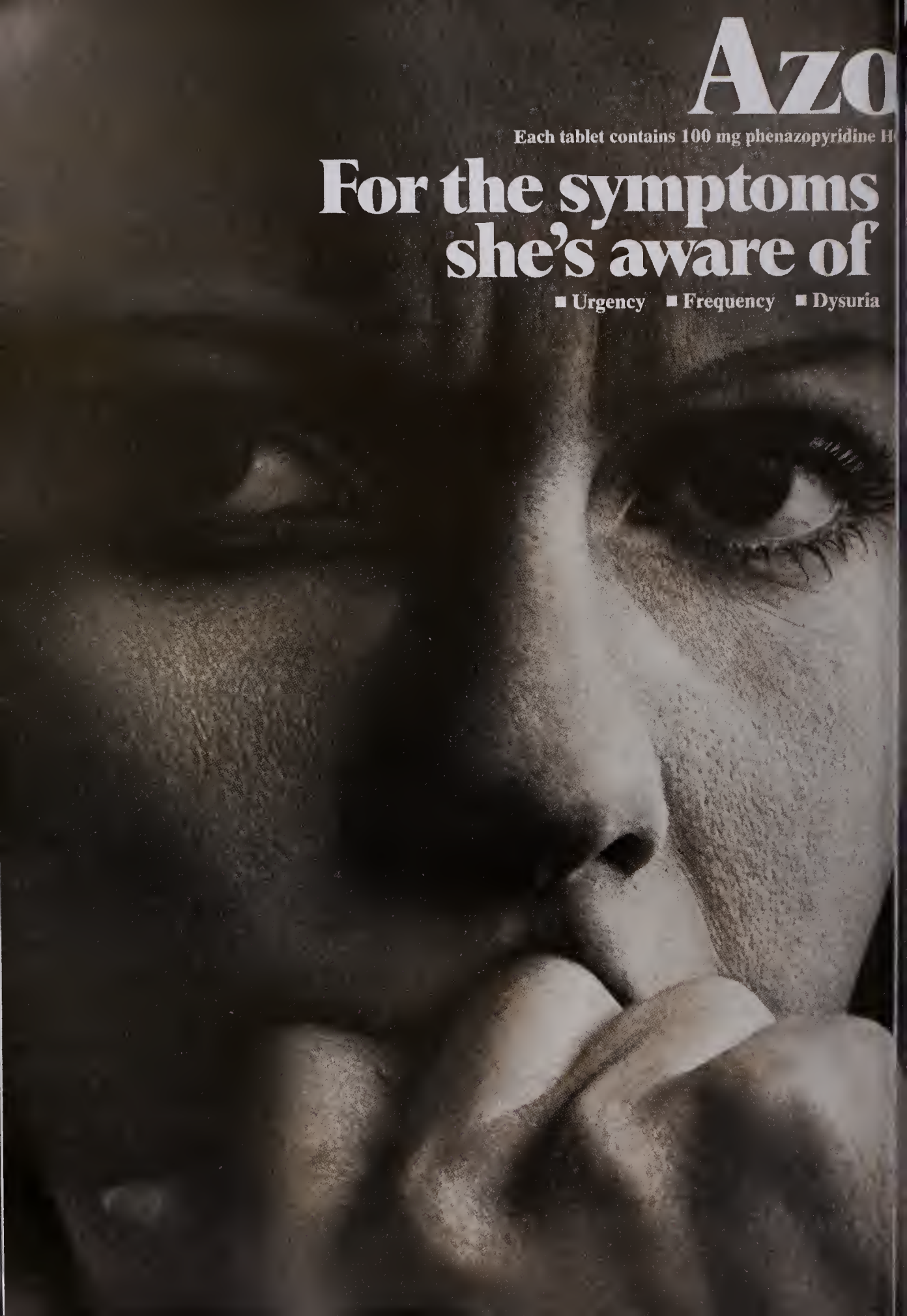
There are no known contraindications in recommended oral doses other than it should not be given in the presence of frank arterial bleeding or immediately postpartum.

ough not all clinicians agree on the value of vasodilators in vascular disease, several investigators[2-5] have reported favorably on the effects oxsuprine. Effects have been demonstrated both by objective measurement[3,5] and observation of clinical improvement.[2,4]

ations: Cerebrovascular insufficiency, arteriosclerosis obliterans, diabetic vascular diseases, thromboangiitis obliterans (Buerger's disease), aud's disease, postphlebitic conditions, acroparesthesia, frostbite syndrome and ulcers of the extremities (arteriosclerotic, diabetic, throm-). **Composition:** VASODĪLAN tablets, isoxsuprine HCl 10 mg. and 20 mg. **Dosage:** Oral—10 to 20 mg. t.i.d. or q.i.d. **Contraindications and ions:** There are no known contraindications to recommended oral dosage. Do not give immediately postpartum or in the presence of ial bleeding. **Side Effects:** Occasional palpitation and dizziness can usually be controlled by dosage reduction. Complete details available oduct brochure from Mead Johnson Laboratories. **References:** (1) Samuels, S. S., and Shaftel, H. E.: J. Indiana Ass. *54*:1021-1023 (July) 1961. (2) Clarkson, I. S., and LePere, D. M.: Angiology *11*:190-192 (June) 1960. Horton, G. E., and Johnson, P. C., Jr.: Angiology *15*:70-74 (Feb.) 1964. (4) Dhrymiotis, A. D., and Whittier, J. R.: . Ther. Res. *4*:124-128 (April) 1962. (5) Whittier, J. R.: Angiology *15*:82-87 (Feb.) 1964.

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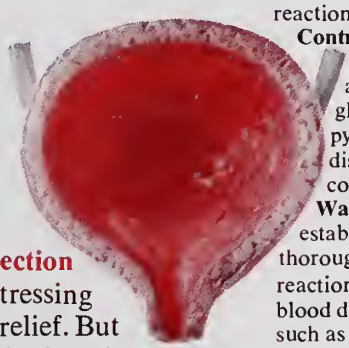
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Urgency, frequency, dysuria—these are the distressing mptoms of cystitis for which she wants immediate relief. But pid control of the infection is equally important to both patient ıd physician. This is the situation that demands dual-action Azo antanol: the analgesic action of Azo (phenazopyridine HCl) for pid relief of pain, the antibacterial action of Gantanol® ılfamethoxazole) to control the bladder infection.

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In from 2 to 3 hours after the initial 2-Gm adult dose of zo Gantanol, therapeutic blood and urine levels begin to control sceptible *E. coli* as well as susceptible gram-negative and am-positive pathogens. Subsequent b.i.d. doses maintain anti- ıcterial levels throughout a 24-hour period—especially important help control bacterial build-up in urine retained during sleeping ours. The usual precautions in sulfonamide therapy, including aintenance of adequate fluid intake, should be observed. The ost common side effects are nausea, vomiting and diarrhea.

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As the antibacterial action of Gantanol begins to control the fection, the analgesic action of the Azo component starts relieving e symptoms associated with her infected, inflamed and irritated adder. In acute, nonobstructed cystitis—when rapid relief of mptoms and early control of infection are essential—prescribe zo Gantanol, the basic therapy that helps your patient feel tter while she gets better.

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basic therapy

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Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. *Important Note:* Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response. Add aminobenzoic acid to culture media for patients already taking sulfonamides. Increasing frequency of resistant organisms currently is a limitation of the usefulness of antibacterial agents. Blood levels should be measured in patients receiving sulfonamides for serious infections, since there may be wide variations with identical doses; 12 to 15 mg/100 ml is considered optimal for serious infections; 20 mg/100 ml should be the maximum total sulfonamide level, as adverse reactions occur more frequently above this level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period. Contraindicated in glomerulonephritis, severe hepatitis, uremia, an pyelonephritis of pregnancy with gastrointestina disturbances, because of phenazopyridine HCl component.

Warnings: Safe use in pregnancy has not been established, and teratogenicity potential has not bee thoroughly investigated. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported; clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts and urinalysis with careful microscopic examination should be performed frequently during sulfonamide therapy.

Precautions: Use with caution in patients with impaired renal or hepatic function, severe allergy, bronchial asthma and in glucose-6-phosphate dehydrogenase-deficient individuals. In the latter, hemolysis, a frequently dose-related reaction, may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia; *allergic reactions:* erythema multiforme (Stevens-Johnson syndrome), skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis; *gastrointestinal reactions:* nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexi pancreatitis and stomatitis; *C.N.S. reactions:* headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia; and *miscellaneous reactions:* drug fever, chills, toxic nephrosis with oliguria and anuria polyarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide and thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Usual adult dosage for acute, painful phase of urinary tract infection is 4 tablets initially, then 2 tablets morning and evening. If pain persists beyond seven days, causes other than infection shoul be sought. After relief has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-re dye (phenazopyridine HCl) will color the urine soon after ingestion.

How Supplied: Tablets, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl, bottles of 100 and 500.

MEETINGS

Approved by FMA Committee on Continuing Education

MAY

17-19 Third Annual Topics in Internal Medicine, University of Florida College of Medicine, Gainesville. For information: Mark V. Barrow, M.D., Dept. of Medicine, University of Florida College of Medicine, Gainesville 32601.

20 Third Annual Stroke Conference, Ponte Vedra Inn, Ponte Vedra. For information: Max Michael Jr., M.D., 655 W. 8th Street, Jacksonville 32209.

JUNE

5-10 Sixth Annual Workshop in Electrocardiography, Tides Bath Club, Redington Beach. For information: Henry J. L. Marriott, M.D., St. Anthony's Hospital, St. Petersburg, Florida 33705.

12-17 Course of Instruction in Coronary Care for the Practicing Physician, Jackson Memorial Hospital, Miami. For information: Louis Lemberg, M.D., U. of Miami School of Medicine, Box 875, Biscayne Annex, Miami 33152.

JULY

10-15 Course of Instruction in Coronary Care for the Practicing Physician, Jackson Memorial Hospital, Miami. For information: Louis Lemberg, M.D., U. of Miami School of Medicine, Box 875, Biscayne Annex, Miami 33152.

Florida State Board of Medical Examiners:
July 23-25, 1972, Miami Beach

For information: Mrs. Marjoriann Keebler, Administrative Assistant, Florida State Board of Medical Examiners, 2717 E. Oakland Pk. Blvd., Fort Lauderdale, Fla. 33306.

National and Regional Meetings Held in Florida

NOVEMBER

2- 4 International Conference on Trichinellosis, Sheraton-Four Ambassadors Hotel, Miami. Sec.: W. C. Campbell, Ph.D., Merck Institute, Rahway, N. J. 07065.

2- 6 Association of American Medical Colleges, Fontainebleau Hotel, Miami Beach. Pres.: John A. D. Cooper, M.D., 1 Dupont Circle, Washington, D. C. 20036.

6-10 American Society of Tropical Medicine and Hygiene, Deauville Hotel, Miami Beach. Sec.-Treas.: George R. Healy, Ph.D., P.O. Box 15208, Emory University Branch, Atlanta, Ga. 30333.

19-22 Pan American Medical Association, Deauville Hotel, Miami Beach. Dir. Gen.: Joseph J. Eller, M.D., 745 5th Avenue, New York 10022.

DECEMBER

2- 7 American Academy of Dermatology, Americana Hotel, Miami Beach. Sec.-Treas.: Frederick A. J. Kingery, M.D., 2250 Northwest Flanders Street, Portland, Oregon 97210.

3- 6 American Society of Hematology, Diplomat Hotel, Miami Beach. Sec.: Steven Robinson, M.D., Beth Israel Hospital, 330 Brookline Avenue, Boston 02215.

1973

MAY

21-24 American College of Obstetricians and Gynecologists, Americana Hotel, Miami Beach. Dir.: Michael Newton, M.D., 79 West Monroe Street, Chicago 60603.

JUNE

11-15 Society of Nuclear Medicine, Americana Hotel, Miami Beach. Exec. Dir.: Mrs. Margaret Glos, 211 East 43rd Street, New York 10017.

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Precautions: Administer with caution to patients with incipient glaucoma, bladder neck obstruction or urinary bladder atony. Prolonged use of barbiturates may be habit-forming.
Side effects: Blurred vision, dry mouth, dysuria, and other atropine-like side effects may occur at high doses, but are only rarely noted at recommended dosages.
Dosage: Adults: One or two tablets three or four times daily. Dosage can be adjusted depending on diagnosis and severity of symptoms. Children 2 to 12 years: One half or one tablet three or four times daily. Tablets may be chewed or swallowed with liquids.

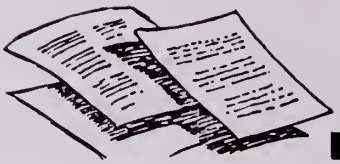
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and the Latin **sedatus,**
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Letters

Dear Editor:

There is a need for more information on biting insects because severe reactions do occur from biting as well as stinging insects. There is also a need for case reports of reactions and results of hyposensitization.

I would like physicians to send me case reports of patients who have had allergic reactions to biting insects and the results of skin testing and hyposensitization, if these were done. I would appreciate detailed case reports, if possible, but a summary will do.

I am compiling case reports of allergic reactions to biting insects, i.e., mosquitos, fleas, kissing bugs, bed bugs, gnats and flies—including horsefly, sandfly and deerfly. I am also interested in reactions to fire ants.

I would like physicians to supply me with case reports of those patients who have had reactions to such insects. Include in your reports, the history of the type of reaction and complications, if any; the immediate treatment; if desensitization were attempted, and the results. Please send to:

CLAUDE A. FRAZIER, M.D.
4-C DOCTORS PARK
ASHVILLE, N.C. 28801

Dear Editor:

On February 10, I resigned my position as President of the Dangerous Substances Guidance Center, Inc. of Broward County and "The Starting Place." Since it is impossible for me to personally thank all the individuals and organizations that have assisted me in making this drug facility a reality over the past three years, I am using this method to extend my deepest appreciation to all of you.

I will be continuing my work in preparing and teaching educational programs in drug dependency at Fort Lauderdale University and, as in the past, will gladly assist my many friends upon their request.

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Indications: Acute, recurrent or chronic urinary tract infections (primarily cystitis, pyelitis, pyelonephritis) due to susceptible organisms (usually *E. coli, Klebsiella Aerobacter, Staphylococcus aureus, Proteus mirabilis* and less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies.

IMPORTANT NOTE: *In vitro* sulfonamide sensitivity tests are not always reliable. The test must be carefully coordinated with bacteriologic and clinical response. When the patient is already taking sulfonamides, follow-up cultures should have aminobenzoic acid added to the culture medium. Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of antibacterial agents including the sulfonamides, especially in the treatment of chronic and recurrent urinary tract infections.

Free sulfonamide blood levels should be measured in patients receiving sulfonamides for serious infections since there may be wide variations with identical doses; 20 mg/100 ml should be maximum total sulfonamide level, as adverse reactions occur more frequently above this level.

Contraindications: Hypersensitivity to sulfonamides, infants less than 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis), pregnancy at term, and during the nursing period.

Warnings: Safety of sulfonamides in *pregnancy* has not been established. Sulfonamides will not eradicate group A streptococci. Deaths associated with sulfonamide administration have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts and urinalyses with careful microscopic examination should be performed frequently during sulfonamide therapy.

Precautions: Use with caution when impaired renal or hepatic function, severe allergy or bronchial asthma is present. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis (frequently a dose-related reaction) may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia, methemoglobinemia. *Allergic reactions:* Erythema multiforme (Stevens-Johnson syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia, allergic myocarditis. *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis, stomatitis. *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, somnia. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L.E. phenomenon have occurred with sulfonamide therapy. Sulfonamides bear certain chemical similarity to some goitrogens, diuretics and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents.

Supplied: Tablets containing 0.5 Gm sulfisoxazole.

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Gantrisin's rapid excretion rate is another reason why it is generally well tolerated. Over 50% of a single oral dose is excreted in 8 hours, over 90% in 24 to 48 hours, so there is little risk of hematuria or crystalluria, and anuria is rare. As with all sulfonamides, adequate fluid intake must be maintained. Complete blood counts and urinalyses, with careful microscopic examination, should be performed frequently.

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Indications: Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (*i.e.*, several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.

Contraindications: Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.

Warnings: When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.

Drug Dependence: Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.

Usage In Pregnancy: The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.

Usage In Children: Not recommended for use in children under 12 years of age.

Precautions: In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorexic agent and a restrictive dietary regimen.

Adverse Reactions: Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.

Dosage and Administration: The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.

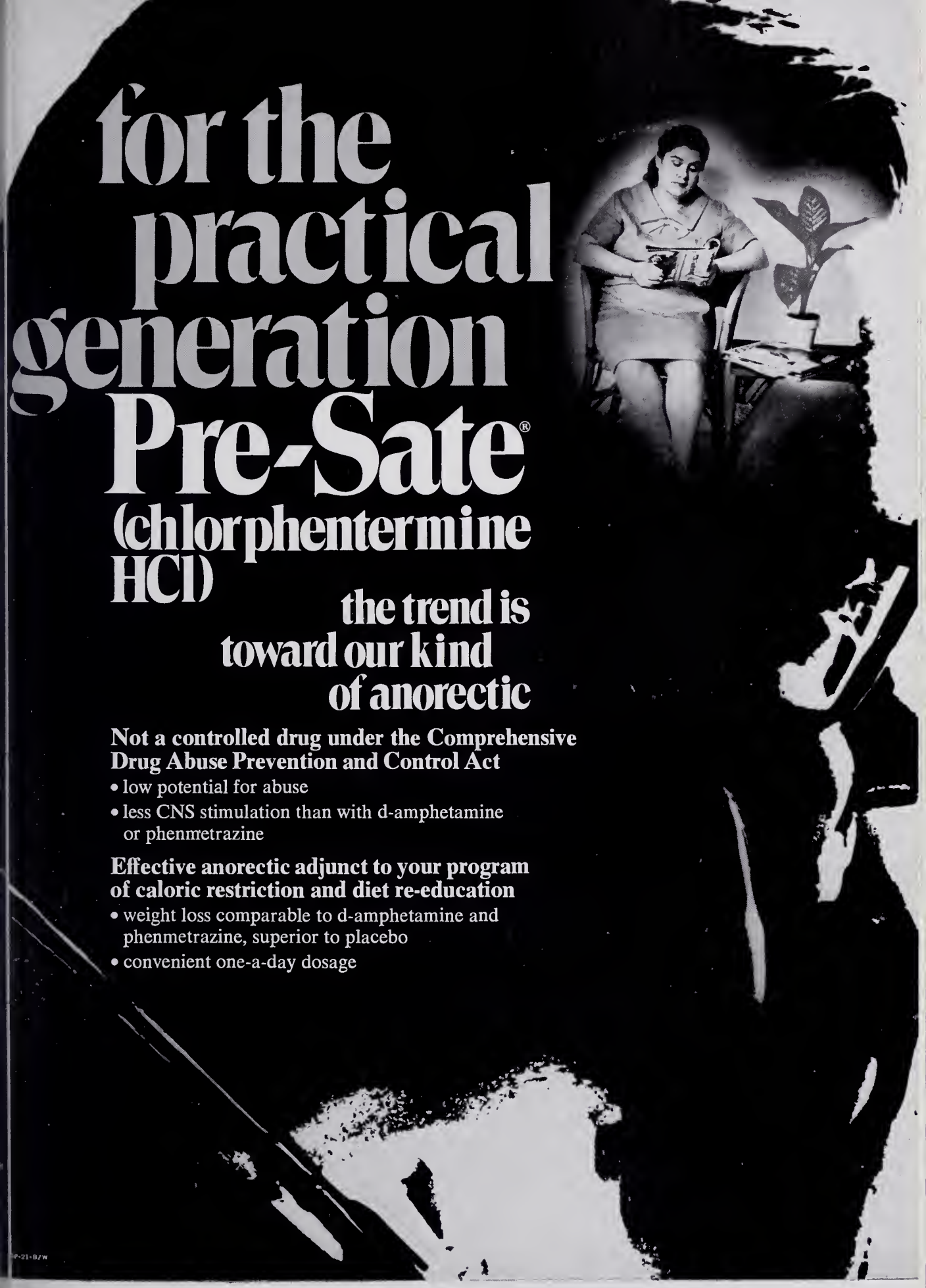
Overdosage: Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.

Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

How Supplied: Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.

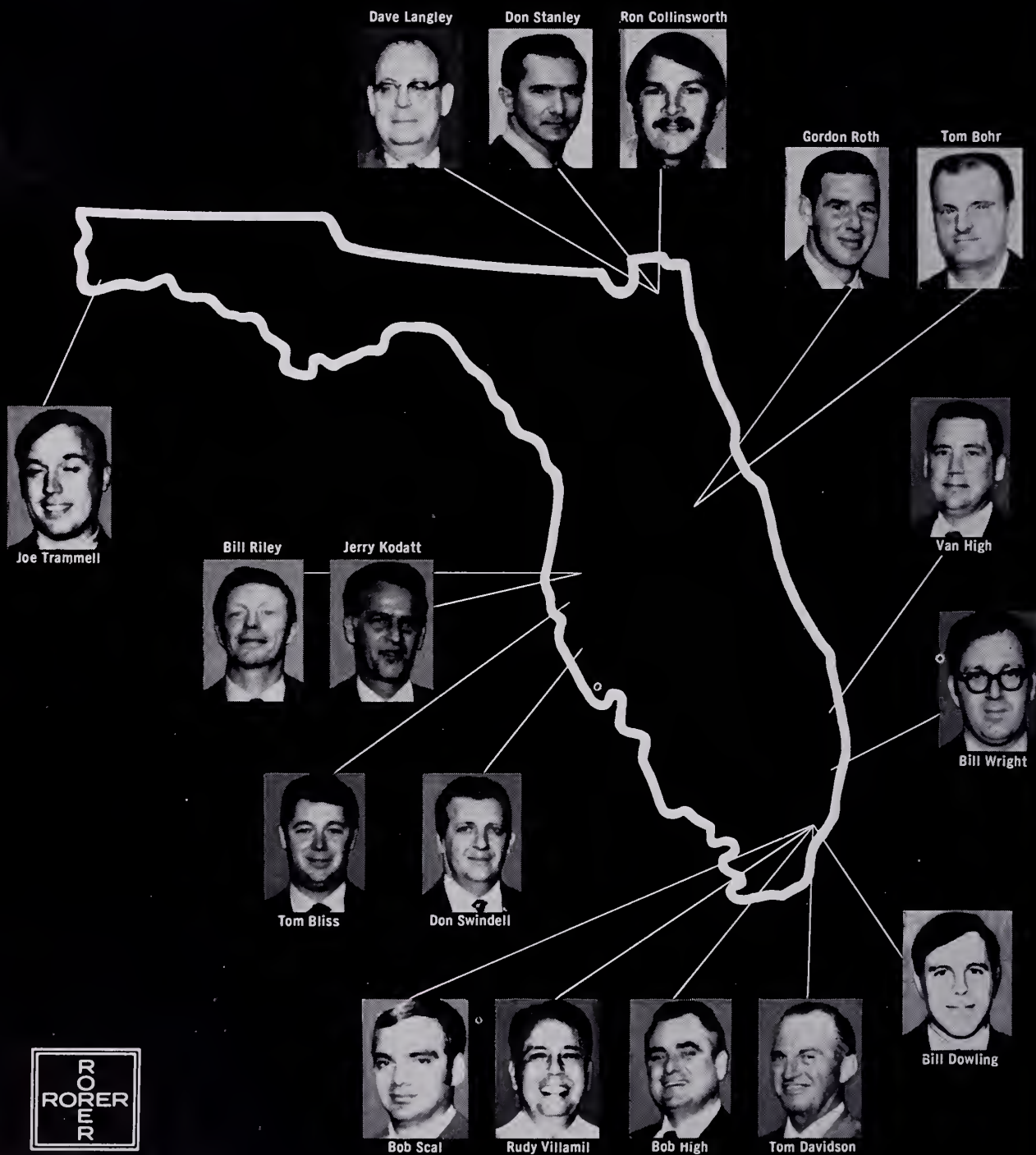
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An orally active hypoglycemic agent principally indicated in relatively mild, adult, maturity-onset, non-ketotic diabetes; also, as a supplement to insulin therapy in selected diabetic patients, it may effect a stabilization of labile diabetes and reduce insulin requirements. Certain patients intolerant to chlorpropamide therapy at usual therapeutic doses have subsequently been successfully managed with Orinase (tolbutamide).

Use in mild asymptomatic diabetic patients with abnormal glucose tolerance tests not responding to diet therapy may result in improvement of the glucose tolerance test.

Use in conjunction with phenformin is indicated when optimal control is not obtained with Orinase or phenformin alone.

Contraindications: Orinase alone is not effective in juvenile or growth-onset diabetes nor in unstable brittle diabetes where insulin therapy is required.

Orinase should not be used: when diabetes is complicated by acidosis, ketosis, or coma, or when a history of repeated bouts of acidosis or coma is obtained; in the presence of other acute complications such as fever, severe trauma, or infections; and in patients with severe renal insufficiency. Insulin is indicated in these circumstances.

Pregnancy Warning: The safety and usefulness of Orinase during pregnancy has not been established either from the standpoint of the mother or the fetus. Animal studies have demonstrated feticidal and teratogenic effects of doses of 1,000-2,500 mg./kg./day, but application to human subjects unknown. Therefore, Orinase is not recommended for the pregnant diabetic, and when administering Orinase to women of childbearing age, these facts should be borne in mind.

Precautions: Diagnostic and therapeutic measures necessa for optimal control with insulin are also necessary with Orina The patient on Orinase must be fully instructed: about t nature of his disease; how to prevent and detect complicatio how to control his condition; not to neglect dietary restrictio develop a careless attitude or disregard instructions relative body weight, exercise, personal hygiene, and avoidance of fection; how to recognize and counteract impending hypog cemia; how and when to test for glycosuria and ketonuria; h to use insulin; and to report to the physician immediately if does not feel as well as usual.

Caution, very close observation, and careful adjustment dose are necessary when: insulin is withdrawn during the t period in order to avoid ketosis, acidosis, and coma; thiaz diuretics are administered which may result in aggravation diabetic state and increased tolbutamide requirement, tem rary loss of control, or even secondary failure; treating patie with impaired hepatic and/or renal function and debilitated, m nourished, or semistarved patients in order to avoid severe hy glycemia which may require corrective therapy over seve days; and treating patients with severe trauma, infection, or s gical procedures where temporary return to insulin or addit of insulin may be necessary. Response to tolbutamide is dim ished in patients receiving therapy with beta blocking age

As some diabetics are not suitable candidates, it is essen that the physician familiarize himself with the indications, lim of application, and selection of patients for therapy.

Patients must be under continuous medical supervision, a during the initial test period should communicate with the ph

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You also know the importance of close monitoring of the patient. Although uncommon, severe hypoglycemia may occur if the dosage is not tailored to suit his requirements.

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And that may be the best recommendation Orinase can have.

Orinase®

0.5 g. tablets

(tolbutamide, Upjohn)

ician daily, and during the first month report at least once weekly for physical examination and definitive evaluation. After a month, examinations are recommended monthly or as indicated. Appearance of ketonuria, increase in glycosuria, unsatisfactory lowering or persistent elevation of blood sugar, or failure to obtain and hold clinical improvement indicate nonresponsiveness to Orinase (tolbutamide). Orinase does not obviate need for maintaining standard diet regulation. Uncooperative patients should be considered unsuitable for therapy. Prescriptions should be refilled only on specific instruction of physician. In treating mild asymptomatic diabetic patients with abnormal glucose tolerance, glucose tolerance tests should be obtained at three- to six-month intervals. Orinase is not an oral insulin or a substitute for insulin and must not be used as sole therapy in juvenile diabetes or in diabetes complicated by acidosis or coma where insulin is indispensable.

If phenformin is prescribed in combination with Orinase, appropriate package literature should be consulted.

Adverse Reactions: Severe hypoglycemia, though uncommon, may occur and may mimic acute neurologic disorders such as cerebral thrombosis. Certain factors such as hepatic and renal disease, malnutrition, advanced age, alcohol ingestion, and adrenal and pituitary insufficiency may predispose to hypoglycemia and certain drugs such as insulin, phenformin, sulfonamides, oxyphenbutazone, salicylates, probenecid, monamine oxidase inhibitors, phenylbutazone, bishydroxycoumarin, and phenyramidol may prolong or enhance the action of Orinase and increase risk of hypoglycemia. Orinase long-term therapy has been reported to cause reduction in RAI uptake without producing clinical hypothyroidism or thyroid enlargement and at high doses is mildly goitrogenic in animals. Photosensitivity reactions, disulfiram-like reactions after alcohol ingestion, and false-positive tests for urine albumin have been reported.

Although usually not serious, gastrointestinal disturbances (nausea, epigastric fullness, and heartburn) and headache appear to be dose related and frequently disappear with reduction of dose or administration with meals. Allergic skin reactions (pruritus, erythema, urticaria, and morbilliform or maculopapular eruptions) are transient, usually not serious, and frequently disappear with continued administration. Orinase should be discontinued if skin reactions persist. Recent reports indicate that long-term use of Orinase has no appreciable effect on body weight.

Orinase appears to be remarkably free from gross clinical toxicity: crystalluria or other renal abnormalities have not been observed; incidence of liver dysfunction is remarkably low and jaundice has been rare and cleared readily on discontinuation of drug (carcinoma of the pancreas or other biliary obstruction should be ruled out in persistent jaundice); leukopenia; agranulocytosis; thrombocytopenia; hemolytic anemia; aplastic anemia; pancytopenia; and hepatic porphyria and porphyria cutanea tarda have been reported.

Supplied: *0.5 g. Tablets*—bottles of 50, 200, 500, and 1,000, and cartons of 100 in foil strips.

For additional product information, see your Upjohn representative or consult the package insert.

The Upjohn Company, Kalamazoo, Michigan 49001

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Upjohn

Phase II - It's the Law

Francis C. Coleman, M.D.

The Phase II Economic Control Program was established by President Nixon under authority given him by Congress.

Special attention was given to the health field with the appointment of a Health Services Industry Committee to advise the Cost of Living Council, the Price Commission and the Pay Board on problems involving providers of health services.

No other segment of our economy has a special committee like this one, an indication of the concern in government about the increasing costs of health care. Many providers believe that this special treatment is discriminatory. Discriminatory or not, the regulations for providers are quite specific.

Hospitals and nursing homes, as institutional providers, must post a sign of a specific size in a prominent place and a list of principal charges must be available for inspection. Non-institutional providers such as physicians, must also post a sign in their office indicating that a fee schedule is available for inspection. The size of the sign is not specified.* This fee schedule must include all of the principal services provided by the physician. The Florida Relative Value Schedule can be used if conversion amounts are included.

The Internal Revenue Service is the enforcement agency for Phase II. IRS agents investigate complaints and make spot checks to determine whether the regulations are being followed. Penalties for noncompliance can be severe, and a fine of up to $5000 can be levied for each violation on conviction.

Physicians as non-institutional providers, can increase their fees up to an aggregate of 2½% annually provided practice costs rise sufficiently to justify the increase and provided that the physician's profit margin—the ratio of professional income to practice costs is not increased. The aggregate increase concept permits a physician to increase one or more fees above 2½%, so long as the total increase in income does not exceed the 2½% limit. If a physician's practice costs increase substantially, a request for an exception to this 2½% limitation can be filed with the district director of the Internal Revenue Service. An application form for requesting this exception can be obtained from him.

To summarize the do's and don'ts under Phase II for physicians:

He *cannot* increase his fees more than 2½% in the aggregate under any circumstances unless he has been approved for an exception to the regulations.

He *cannot* increase his fees other than to meet the increased costs of running his practice, even within the 2½% guideline.

He *cannot* increase his fees to cover increased practice costs if he has already provided for meeting those increased costs by increasing productivity.

He *cannot* increase his profit margin if he has increased his fees.

He *cannot* refuse to show his fee schedule to anyone who asks to examine it.

Thus, there are quite a few restrictions on the physician. To balance the picture, however, let's take a look at what he *can* do.

He *can* increase his prices up to 2½% to meet increased costs of running his practice, provided he has not already covered the increased costs through productivity gains.

He *can* increase the price of one type of service more than 2½% to cover increased costs of running his practice, just so long as the aggregate price increase across his entire practice does not exceed 2½%.

He *can* increase his practice revenue through productivity as much as he wishes if he has not increased his fees.

He *can* increase his profit margin as much as he wishes if he has not increased his fees.

Even if he has increased his fees under the guidelines, he *can* increase his practice revenue by working longer hours and seeing more patients.

He *can* apply for an exception to the 2½% guidelines.

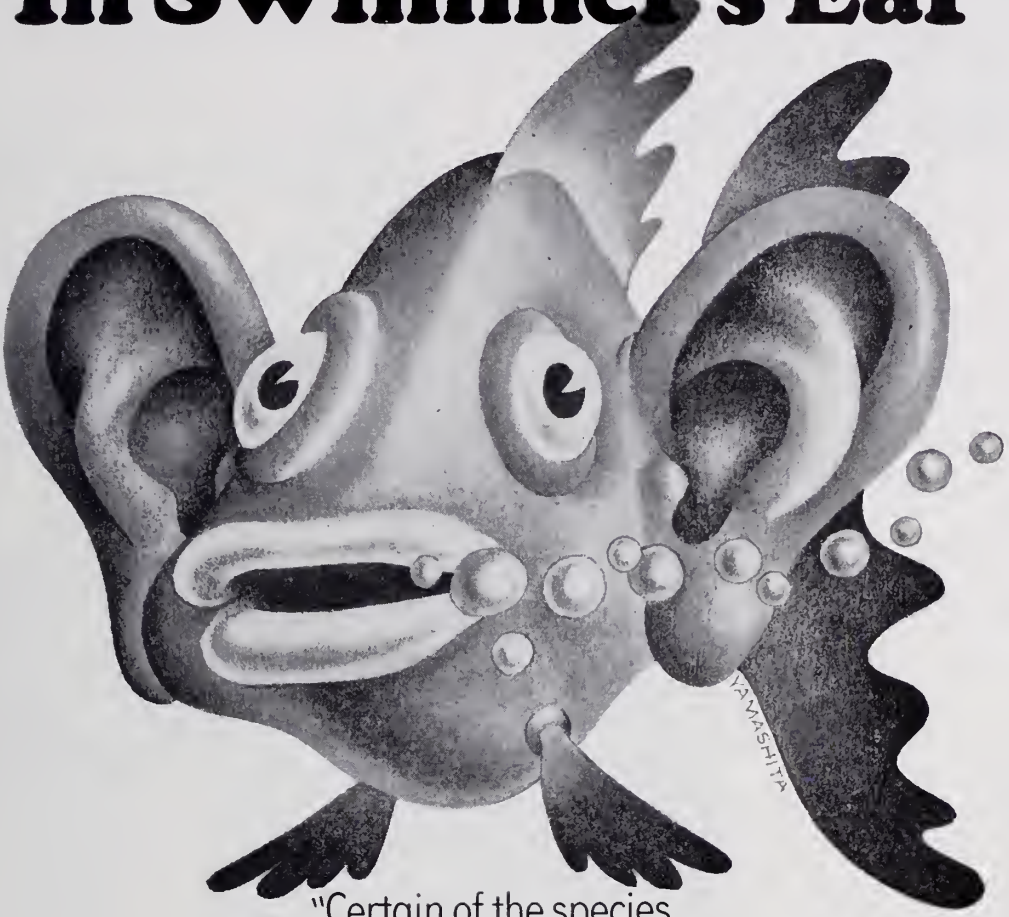
How long Phase II will last is anybody's guess. Present congressional authorization expires April 30, 1973. There could be a Phase III.

In the meantime, Phase II is the law. Violators should be prepared for a visit from the Internal Revenue Service.

▶ Dr. Coleman, 4600 North Habana, Tampa 33614.

*See April JFMA (page 10) for full page sign to post in your office.

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FURACIN (nitrofurazone) and Micofur (nifuroxime) are active against a variety of gram-positive and gram-negative organisms. Activity versus Pseudomonas sp. is limited to certain strains. Micafur (nifuroxime) is active against Candida (Manilio) albicans.

Precautions: Sensitization may occur with prolonged use and is more likely to develop in eczematous otitis externa. To minimize such reactions (a) limit application to a week or less, and (b) avoid use of excessive amounts which may run down the face.

This preparation is not indicated for use in treatment of cholesteatoma, where surgical intervention is necessary.

Supplied: Bottle of 15 cc. with dropper.

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Pinworm therapy is often a family affair





Contraindications: History of hypersensitivity to thiabendazole.
Warnings: If hypersensitivity reactions occur, drug should be discontinued immediately and not resumed. Rarely, erythema multiforme has been associated with thiabendazole therapy; in severe cases (Stevens-Johnson syndrome), fatalities have occurred. Because CNS side effects may occur quite frequently, activities requiring mental alertness should be avoided. Safe use in pregnancy or lactation has not been established.
Precautions: Ideally, supportive therapy is indicated for anemic, dehydrated, or malnourished patients prior to initiation of anthelmintic therapy. In presence of hepatic or renal dysfunction, patients should be carefully monitored.
Adverse Reactions: Most frequently encountered are anorexi nausea, vomiting, and dizziness. Less frequently, diarrhea, epigastric distress, pruritus, weariness, drowsiness, giddines and headache have occurred. Rarely, tinnitus, hyperirritabilit numbness, abnormal sensation in eyes, blurring of vision, xanthopsia; hypotension, collapse; enuresis; transient rise in cephalin flocculation and SGOT; perianal rash, cholestasis ar parenchymal liver damage; hyperglycemia; transient leukope a; malodor of the urine, crystalluria, hematuria; appearance of e Ascaris in the mouth and nose. Hypersensitivity reactions

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nclude: fever, facial flush, chills, conjunctival injection, ngioedema, anaphylaxis, skin rashes, erythema multiforme including Stevens-Johnson syndrome), and lymphadenopathy.
Supplied: Chewable tablets, containing 500 mg thiabendazole, in boxes of 36, strip packaged, individually foil wrapped; Suspension, containing 500 mg thiabendazole per 5 cc, in bottles of 120 cc.

For more detailed information, consult your MSD representative or see the Direction Circular. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

MSD
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addendum

INDICATION | DOSAGE SCHEDULE

MINTEZOL® (Thiabendazole, MSD) has demonstrated effectiveness against a broad spectrum of nematode infestations, whether encountered singly or in combination. Dosages are weight related; therefore, a weight-dose chart is included in the Direction Circular for your convenience when writing a prescription. MINTEZOL should be given after meals if possible.

INDICATIONS	DOSAGE (1st Day)	ADDITIONAL REGIMEN	COMMENTS
Pinworm disease	Two doses of 1 tablet/50 lb	Repeat 7 days later	This regimen is designed to reduce the risk of reinfection. However, if not practical, repeat the regimen the next day.
Threadworm,* large roundworm,* hookworm,* and whipworm* disease	Two doses of 1 tablet/50 lb	Repeat the next day	Alternatively, a single dose of 2 tablets/50 lb may be given. However, a higher incidence of side effects should be expected.
Creeping eruption	Two doses of 1 tablet/50 lb	Repeat the next day	If active lesions are still present 2 days after completing this regimen, a second course is recommended.
Symptoms of trichinosis* during the invasive phase of the disease	Two doses of 1 tablet/50 lb	Repeat for 2 to 4 successive days	The optimal dosage for the treatment of trichinosis has not been established.

The recommended maximal daily dosage is 3 g (6 tablets).

*Clinical experience with thiabendazole for treatment of each of these conditions in children weighing less than 30 lb has been limited.

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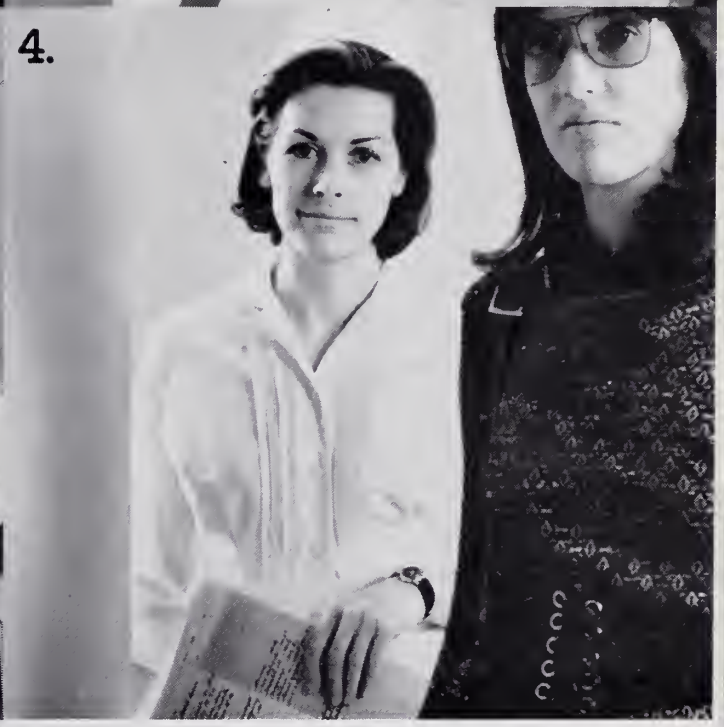
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JFMA
THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.
MAY, 1972 • VOLUME 59 • NUMBER 5

One Hundred Consecutive Cases of Aorto-Coronary Bypass Surgery

FREDERICK K. VONTZ, M.D., SAM E. MYRICK JR., M.D., JOHN R. IBACH JR., M.D. AND LARRY H. BIRCH, M.D.

Despite general acceptance of aorto-coronary bypass as a palliative procedure, it has a relatively short history. Therefore, those performing this surgery have a duty to contribute to its assessment and to help determine its long-range benefits.

From the early hesitating attempts, the procedure now has become a regular part of our surgical schedule. From May 1969 to September 1971, we used this treatment method for the first 100 consecutive patients at Baptist Memorial Hospital in Jacksonville—87 male and 13 female ranging in age from 31 to 69. A particular effort has been made to restudy them early (eight days) and late (three months) after surgery so as to gain insight into the fate of the vein grafts.

The need to integrate the efforts of a well-functioning cardiac physiology laboratory, an experienced surgical team and excellent postoperative care cannot be overemphasized.

All the patients underwent preoperative coronary arteriography and ventriculography and several had complete cardiac catheterization. Treadmill and other stress evaluations were part of standard work-up when not contraindicated. Those selected for study had (1) a typical history of angina; (2) history of coronary insufficiency, myocardial infarction (both transmural and subendocardial) or infarction prodromata; (3) a treadmill or Masters' stress test indicating myocardial ischemia; (4) congestive heart failure possibly due to coronary artery disease; (5) acquired valvular heart disease in patients being considered for valve surgery; (6) history of variant angina (Prinzmetal), and (7) selected patients with questionable chest pain who required surgery of diseased carotid, femoral, or aorto-iliac systems.

Indications

Successful vein grafting requires a patent distal vessel with good runoff and a lumen estimated to be at least 2 mm. at the proposed site of anastomosis. Stenosing lesions are usually found within the first two or three centimeters of the vessels on the left side, while on the right side even more distal disease can be dealt with adequately, sometimes by a combination of endarterectomy and vein grafting.

The following reflect our current criteria for aorto-coronary bypass provided the vessels are suitable for grafting distal to the obstructions (Table 1):

1. Refractory angina with demonstrated obstructive disease.
2. Preinfarction angina.
3. Left ventricular failure when due to:
 a. Left ventricular aneurysm.

b. Large areas of dyskinesia in combination with localized areas of obstruction.
c. Papillary muscle dysfunction producing mitral valve incompetence.

4. Severe stenoses in several vessels proximally.
5. Major stenosis of the left main coronary artery.
6. Major stenosis of the left anterior descending coronary artery proximal to its first septal branch.

Our experience with surgery in the acute stages of myocardial infarction is limited but quite promising. We do advocate that in certain instances patients with acute infarction or prodromata come to study promptly so that proper surgical therapy can be instituted.

Cardiogenic shock has proven to be difficult to treat both surgically and medically. We are doubtful at this time that surgery can improve the dismal results of conservative treatment.

Contraindications

While the indications for aorto-coronary bypass surgery are still being amended, the contraindications have manifested themselves early in the development of this procedure:

1. Age beyond 70 makes a successful operation of this magnitude doubtful, primarily in view of the quantity of life remaining.

2. Smoking leads to enormous pulmonary complications which are rarely survived.

3. Obesity, even mild or moderate, not only burdens the surgeon but leads to difficult operative and postoperative problems.

4. Systemic diseases such as malignancies, renal insufficiency and severe emphysema preclude success.

5. Narcotic addiction based on angina is not changed by surgery and such individuals are rejected.

6. Diabetes mellitus, particularly when complicated, poses specific hazards. Small vessel involvement of heart, brain, liver and kidneys often produces severe complications.

7. Multiple stenoses in the distal segments of the coronary vessels are considered unsuitable for grafting. Such peripheral stenoses preclude adequate runoff and prolonged graft patency.

Table 1.—Indications for Surgery in 100 Patients.

Angina	79
Congestive heart failure with angina	7
Previous infarctions with aneurysms—no angina	6
Main stenosis	4
Preinfarction	4

Anesthesia

The preoperative sedation usually includes a tranquilizer and a narcotic given prior to insertion of a central venous pressure cannula under local anesthesia in the patient's room. The venous cannula is kept open with a solution of 500 cc. of 10% dextrose and water with 40 mEq. of KCl and 10 units of regular insulin to avoid potassium depletion. This is given at the rate of 100 cc. per hour. In addition, atropine is given to suppress vagal reflexes during induction of anesthesia.

On arrival in the operating room the patient is connected to an EKG and, depending upon ventricular function, a radial artery is cannulated percutaneously with a Teflon Angiocath. If ventricular function is good, this may be deferred until after induction. Arterial and venous pressures are monitored continuously. An additional IV of 5% dextrose and a balanced salt solution is started.

Induction is carried out after preoxygenation with either thiopental (1.5 mg./kg.) or ketamine (4-5 mg./kg.) IV. Endotracheal intubation is achieved after IV succinylcholine (1 mg./kg.) using a sterile, disposable endotracheal tube. Anesthesia is maintained via a sterile circle absorber system utilizing N_2O:O_2 in a 3:2 ratio and 0.3-0.4% methoxyflurane delivered from an Ohio Vernitrol, supplemented with d-Tubocurarine. The initial dose of the curare is 0.3-0.5 mg./kg., with additional doses given at regular intervals and no attempt is made to reverse the drug at the end of surgery. In addition to CVP and arterial pressure, esophageal or tympanic membrane temperature and urinary output is continuously monitored, along with hemoglobin and electrolyte levels.

Coronary vasodilation is maintained by sublingual isosorbide dinitrate, 5 mg., prior to leaving for the operating room. If blood pressure and, during the pump run, perfusion pressure are adequate, nitroglycerin solution 0.4 mg./cc. is given at the rate of .4 mg./hour intravenously, or into the pump.

Surgical Procedure

From the early difficult struggles to obtain adequate exposure of small arteries hidden in fat or located on the diaphragmatic surface of the heart, the surgical procedure has now progressed to a routine set of events which allows a prompt approach to all vessels in correlation with the cinearteriographic findings. Our current procedure as it has evolved over the course of several months is described.

After induction of endotracheal anesthesia and preparation of the anterior body surface and draping, the greater saphenous vein is removed while simultaneously a median sternotomy is performed. The ascending aorta is chosen as inflow site. Cardiopulmonary bypass using a priming solution of two units of blood, 1500 cc. Normosol-R, and 30 Gm. albumin is instituted with a Bentley disposable oxygenator. The left ventricle is immediately decompressed through an apical sump, carefully avoiding the distal left anterior descending coronary artery which usually passes around the apex onto the diaphragmatic surface of the heart and serves as an important collateral channel.

The vessels in question are then palpated and the anastomotic sites determined. The reversed saphenous vein and the recipient coronary artery are then joined using a continuous 6-0 suture of monofilament. The lumen of the recipient artery is carefully probed proximally and distally with metal dilators sized from 1-3 mm. This allows us to determine the lumen of the vessel and also serves as a stent during construction of the anastomosis. Vessels of less than 2 mm. diameter promise little hope of late patency.

Approximately 15% of patients require an endarterectomy to achieve a lumen large enough to make anastomosis with a vein practical.

We have developed a special technique for arteries which are hopelessly clogged by atheromatous and fibrous material, avoiding any contact with the lumen of the artery and therefore preventing future clotting. The artery—most often the distal right—is incised and by careful dissection the core then loaded on an instrument and while gentle traction is exerted on the core, the outside of the vessel is massaged gently but firmly with a dissector which eventually leads to the release of a tapered specimen, the taper indicating separation of the core at the level of its junction with normal intima. This produces a smooth internal layer which remains sufficiently strong to allow routine anastomosis with a vein graft. When done properly, the resultant anastomosis will carry a high flow of blood. It is possible, with this technique, to salvage vessels which would otherwise be too small for grafting (Fig. 1).

Cross-clamping of the aorta assures a quiet field and allows an accurate anastomosis. Cross-clamping is limited to ten minutes at a time and after release of the clamp the heart will immediately return to a sinus mechanism without intervening ventricular fibrillation. The promptness with which the heart returns after clamp release is a gross but reliable indicator of the cardiac performance. The clamp is only reapplied when cardiac action has returned to a sinus rhythm.

In patients requiring more than one graft a special sequence is followed in which the most difficult anastomosis, usually that of the circumflex artery, is performed first, followed by the left anterior descending, then the right coronary artery.

Areas of akinesia, large areas of fibrosis and aneurysms are excised after the grafting procedure has been completed.

The position of vein grafts must be such that when the sternum is approximated and all chambers of the heart properly filled, no kinks, twists



Fig. 1.—Postoperative study depicting vein graft filling distal right coronary artery with anastomosis at the arrow. Endarterectomy was necessary to achieve adequate lumen.

or other flow disturbances are produced. The typical appearance of a triple vein graft is depicted in Figure 2.

The veins must not be too long nor too short. A desirable opening at the anastomotic site is usually indicated by the "cobra head" appearance of the vein at both ends.

Each anastomosis is tested with heparinized saline and additional sutures are placed when necessary. The junction of aorta and vein graft is also performed under aortic cross-clamping with excision of an elipse of aortic wall so as to avoid narrowing of the opening later. Before release of the aortic cross-clamp, all air is carefully evacuated. We avoid Y or T anastomoses and prefer that each vein graft have its separate origin from the aorta.

Pump support is very cautiously withdrawn after completion of the grafting procedure and inotropic agents are used if ventricular function is marginal. After adequate pericardial drainage and hemostasis, the sternum is approximated using #5 Dacron sutures. These are preferred to radio-opaque wire which has a habit of fatiguing and breaking particularly when prolonged mechanical respiratory support is needed postoperatively. Pacing wires and left atrial pressure lines are used when indicated.

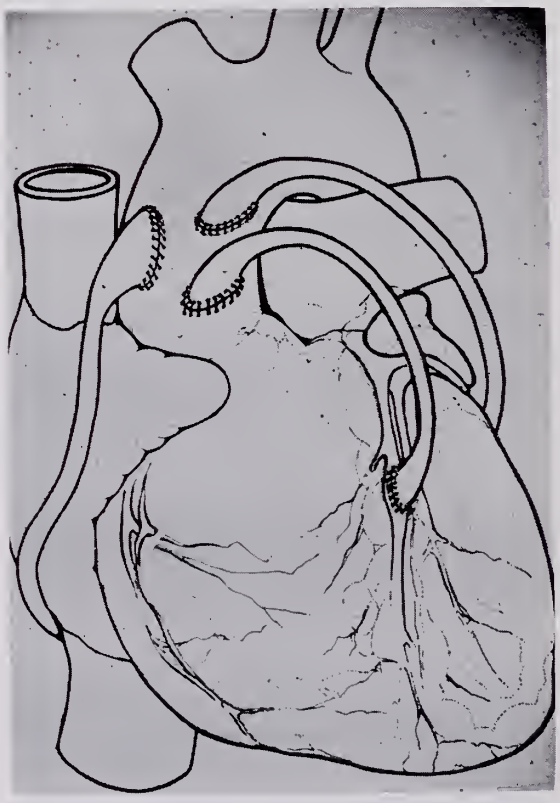


Fig. 2.—Typical arrangement of a triple vein graft with right coronary artery, circumflex and left anterior descending coronary arteries and their corresponding saphenous vein grafts. The right coronary artery and distal coronary artery grafts are anastomosed to recipient vessels on the diaphragmatic surface of the heart and are not visible. Note the arching of the circumflex and left anterior descending grafts across the pulmonary artery and right ventricular outflow tract.

Anastomoses are routinely made in the distal RCA just before its division into the posterior descending artery and the communicating branch to the circumflex system. This allows direct delivery of blood flow to the area of supply and is also more practical when endarterectomy is required.

Anastomoses to the left anterior descending artery are mostly performed in its midportion.

As courtesy to our cardiologists, we mark the origin of the vein grafts from the aorta with large hemoclips or metallic rings. This facilitates their identification during postoperative catheterization and saves needless dye injections. They are particularly valuable when a vein graft is occluded or difficult to enter with the catheter tip.

The postoperative care follows the standards of other cardiac surgical procedures. Very special emphasis, however, is placed on the strict avoidance of pulmonary or left ventricular overload. The already impaired myocardium of coronary artery patients is particularly intolerant of distention. Fluids are carefully controlled and restricted to 100 cc. 80 kg./hr., and liberal use is made of diuretics at the earliest sign of pulmonary overload. Judicious use of epinephrine is also part of our regimen as soon as we suspect left ventricular failure.

Single vein grafts were performed in 30 patients, double vein grafts in 38, triple vein grafts in 16 and a quadruple vein graft in one patient. Single vein graft combined with aneurysmectomy was done in ten patients while five patients underwent resection of an aneurysm after double vein grafting.

Clinical Results

We have divided the clinical results into four arbitrary groups, excellent, good, improved, not improved.

Excellent were those patients who obtained complete freedom from angina, had no signs or symptoms of heart failure, had returned to their usual activity, and had become independent of any drug regimen.

The result was termed good when the patient had returned to full physical activity, had re-

sumed his preoperative occupation, was free of angina or needed only occasional medication for its relief or was limited to less than maximal exertion.

Improved were patients who depend on occasional coronary vasodilators and who are limited in their activities but nonetheless substantially improved in their quality of life compared to the preoperative state.

Unimproved are those who have failed to gain any benefit from the procedure. Listed among the unimproved are also patients who, although clinically well, have been found to have all grafts occluded postoperatively and those who had myocardial infarctions immediately following surgery.

A total of 43 patients were classified as excellent, 20 as good, 12 as improved and six unimproved.

There were six intraoperative deaths. These patients died due to intractable left ventricular failure following grafting and cessation of cardiopulmonary bypass. Supportive measures included inotropic agents and repeated cardiopulmonary bypass. All patients had severe triple vessel disease except one and their preoperative ventricular function had been rated as poor. Except for one patient, all had a history of previous myocardial infarction. We were unable to establish a relationship between these deaths and aortic cross-clamping time, adequacy of digitalization or other definable parameters aside from poor ventricular function and extensive disease. None of these patients died from intraoperative catastrophies or recognizable technical errors.

In the postoperative period, seven patients expired. Their deaths occurred six hours to three weeks following operation. Three diabetics had undergone triple vein grafts. In two of these, carotid bruits had been present prior to operation and both had sustained severe cerebral ischemia during a reexploration for postoperative hemorrhage. A third diabetic sustained massive cerebrovascular accident six hours postoperatively. All died of neurologic complications. One patient died from graft disruption at the aortic anastomosis 72 hours after the operation and could not be retrieved despite immediate attention. Neither infection nor aortitis could be documented as reason for the disruption.

One patient died with severe interstitial pulmonary inflammation four days postoperatively. His death was attributed to intractable left ventricular failure possibly due to ventricular distention at the time of surgery. Sudden arrhythmia was the cause of death in one patient who had undergone operation for severe left main artery stenosis and had a cardiac arrest at the time of induction of anesthesia but had made an initial successful comeback after double vessel grafting.

One patient died three weeks postoperatively from severe bilateral pulmonary fibrosis and pneumonitis. Unknown to the surgeon, he had continued smoking until the day prior to surgery. All patients who died during or immediately following the operation underwent postmortem examinations. Their grafts were patent. Death was not due to graft occlusion.

Since the beginning of our series, three late deaths have occurred, at six weeks, 13 and 14 months postoperatively.

A 66-year-old white male died six weeks after double coronary artery grafting. His death occurred at home and no details could be obtained nor could a postmortem examination be arranged. It is assumed that he died from an arrhythmia. He had far advanced triple vessel disease.

A 52-year-old white male died 13 months postoperatively from intractable left ventricular failure. At the time of operation, the left sided vessels were found unsuitable for grafting and only a right sided graft with a double Vineberg procedure could be performed.

A 64-year-old male died 14 months after left anterior descending grafting. The patient also had aortic valvular stenosis which, because of its relatively minor gradient, was not treated by valve replacement. He had total relief from angina postoperatively and died from the consequences of a postcholecystectomy empyema. At postmortem examination the vein graft to the left anterior descending coronary artery was found to be smooth and patent (Fig. 3). The transition from the vein graft to coronary artery was not recognizable macroscopically. The previously narrowed proximal left anterior descending artery had progressed now to complete occlusion. Distally the vessel remained patent and free from recognizable disease.

In three instances we made attempts to retrieve patients dying from acute myocardial disease. Their course is described in detail.

The first was a 44-year-old male who underwent double grafting four weeks following an anterior myocardial infarction because of severe and persistent congestive heart failure. The patient had an old posterior myocardial infarct and

also complete occlusion of his abdominal aorta below the renal level. A double vein graft was performed and ventricular function became excellent. Congestive heart failure disappeared promptly but the patient died four weeks later from renal failure despite hemodialysis.

A 32-year-old male had been admitted with a posterior myocardial infarct and soon thereafter sustained an AV block. On the 10th day postinfarct, ventricular fibrillation occurred. Numerous defibrillations resulted only in temporary improvement. Because of his excellent neurologic status after 90 minutes of resuscitative efforts, his young age and the persistent ventricular fibrillation, extreme measures seemed justifiable. He was found to have a solitary right coronary artery stenosis proximally with a large fresh clot occupying the entire course of the dominant right coronary artery. The whole diaphragmatic surface was purple and noncontractile. A vein graft to the distal RCA resulted only in temporary improvement of ventricular function and he died on the operating table after two hours of continued pump support. He was the only patient in this series who had not undergone previous cardiac catheterization. At postmortem examination the vessels of the left side were found to be free of disease.



Fig. 3.—Postmortem specimen, after death from unrelated cause, showing patent vein graft originating from aorta at upper left hand corner of the picture arching across the pulmonary outflow tract and unroofed with anastomosis into the left anterior descending at the bottom of the photograph. The distal left anterior descending artery remains patent 13 months after surgery while the proximal artery is completely occluded.

A 69-year-old male who had been catheterized because of status anginosus was found to have severe far advanced triple vessel disease. After catheterization, massive preinfarction-type angina ensued. Since the anatomy of his lesion had been well localized and enzyme changes had not yet occurred, he was brought to our institution and prepared for double vein grafting. He sustained two cardiac arrests during transfer and was resuscitated and operated but failed to produce sufficient cardiac function after bypass and died on the operating table.

Postoperative hemorrhage from the mediastinum occurred in six patients (Table 2). All were promptly returned to the operating room where hemostasis was accomplished. In only one instance were we able to document bleeding from a definite site; namely, a suture line defect in the left anterior descending anastomosis. In the others, generalized oozing was present and had not responded to the usual measures. All survived except two diabetics who sustained cerebrovascular accidents either during or shortly after reexploration for bleeding.

Myocardial infarctions occurred in the immediate postoperative period in three patients. All survived but one developed a massive left ventricular aneurysm from his infarct which was due to graft thrombosis proven at repeat catheterization.

Sternal dehiscence occurred in four. This happened in patients who had not discontinued smoking. All four had severe pulmonary infections and had required prolonged respiratory support and tracheotomy. Two of the four patients had the preinfarction syndrome and were smoking up to the point of operation. Because of the urgency of their condition, there was not sufficient time for tracheobronchial toilet. A severe sternal infection requiring multiple saucerizations occurred early in the series again in a

TABLE 2.—COMPLICATIONS.

Postoperative hemorrhage	3
Myocardial infarction	3
Sternal dehiscence with tracheotomy	4
Sternal infection with tracheotomy	1
Bowel obstruction	2
Renal failure, late	1

previously heavy smoker who also had severe pulmonary infection requiring tracheotomy. All healed promptly after secondary closure.

Two patients developed bowel complications, one a total volvulus 72 hours postoperatively, another a limited area of small bowel necrosis eight days postoperatively. The etiology of both lesions was never clarified. Both survived laparotomy and are doing well.

A diabetic patient suffered a transient bout of total renal shutdown three weeks after operation but survived and is doing well now.

Presently the success of aorto-coronary bypass grafting cannot be judged by any single parameter. Its merits are rather a composite of clinical result, graft patency, improvement of ventricular function, and physiologic changes—some of which are in sharp discrepancy with the expected result.

Certainly nothing is more fundamental to the success of a bypass operation than the patency of the grafts. It has been our aim to evaluate patency and clinical result early, that is just before discharge, and six months or more after operation so as to gain insight into the fate of vein grafts, myocardial reconditioning, and progressive distal disease.

Forty-one patients have been restudied six days to one year postoperatively. We found the information of early postoperative studies helpful in the immediate management of patients after discharge. In 41 patients a total of 76 saphenous vein grafts have been examined so far. Twelve were found to be obstructed. This makes for an overall patency rate of 82%. The highest failure rate (30%) occurred in the left anterior descending coronary artery. Surprisingly only one of 19 circumflex artery grafts was found to be closed. The right coronary artery was occluded in four of 23 patients. Among the 23 right coronary artery vein grafts, seven were performed after extensive endarterectomies and only one of these was found to be occluded. Only in two patients was graft occlusion heralded by dramatic clinical events in the form of an acute myocardial infarction. In the others occlusion occurred unnoticed.

Analyzing our postoperative studies, we confirmed that there is a certain attrition in graft patency. Early rates of 90-95% will decline to 80-85% through the next year.

A very deliberate restudy program is underway to follow these patients and determine whether further decrease in patency must be expected or whether graft occlusion plateaus after several months.

In no case of occlusion did we find that the thrombosis extended beyond the vein graft into the recipient vessel. The recipient vessels were in no case made worse.

Conclusions and Comments

In four to 30 months, better than 70% of our patients who have undergone aorto-coronary bypass surgery are clinically improved. Many have become totally asymptomatic, others have returned to gainful employment with only occasional requirement for medication.

Three were operated as salvage attempts, eight as emergencies (preinfarction, critical left main stenosis), the remainder electively, after a minimum of four weeks nicotine abstention and weight loss when indicated. Of 22 patients with very poor ventricular function, 14 (65%) survived and achieved great clinical improvement. We have made no attempt to tailor our statistics by refusing operation to desperately ill people.

We have learned to assess operability and technical feasibility of grafting by continued reevaluation of our work and correlation with cineangiography and physiologic data.

Surgically, the single most important improvement has been the introduction of fractionated aortic cross-clamping. Since the adoption of this technique, only a single operative mortality has occurred during the last 70 cases. The technical advantages of an absolutely quiet field are obvious. We feel that digitalis aids the recovery of the anoxically arrested heart and therefore recommend that all patients are digitalized prior to surgery.

Through an aggressive approach to the preinfarction syndrome and other precursors of myocardial damage, we hope to preclude needless loss of active muscle. Undoubtedly, the near future will produce sufficient data to justify earlier study and surgery of patients with impending and acute infarctions.

Acknowledgments

Special thanks are due to Angel de la Torre, M.D., Chief, Division of Cardiology, University Hospital of Jacksonville, who generously contributed, along with the many referring physicians, to our efforts.

A particular note of recognition is owed to John A. Rush Jr., M.D., Paul K. Newman, M.D., and John C. Kruse, M.D., of the Department of Anesthesiology, Baptist Memorial Hospital, for their untiring efforts in taking care of these patients. John C. Kruse, M.D., contributed the section on anesthesia.

H. E. Snyder, M.D., participated in the surgery and care of some patients in the early portion of the series.

Paul D. Willis, M.D, Department of Radiology, St. Luke's Hospital, performed several of the coronary arteriograms.

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Fingertip Preservation After Distal Phalangeal Removal

John Wesley Snow, M.D. and Lewis J. Obi, M.D.

Osteomyelitis of the distal phalanx can occur after direct trauma, by secondary invasion from a felon[1] or by hematogenous spread from some other distant site. This can usually be controlled by the judicious use of antibiotics, conservative debridement, rest and soaks. The occasional case will be encountered, however, which is resistant to all the usual methods of treatment, which smolders for months and eventually leads to amputation of the fingertip.



Fig. 1.—Subperiosteal removal of the distal phalanx, index finger. This police officer sustained a human bite through the nail and nailbed four months previously. Osteomyelitis of the distal phalanx persisted in spite of incision and drainage and antibiotic treatment.





Figs. 2. and 3.—One month postoperative removal of distal phalanx demonstrating residual flexion and extension of the fingertip. (Nail deformity secondary to initial injury.)

In the past three years we had three patients who had total subperiosteal removal of the distal phalanx. This resulted in cessation of the inflammatory process and is superior to amputation since a stable, mobile fingertip with normal sensation is preserved. Stability is due to the large amount of circumphalangeal scarring which inevitably occurs secondary to the smoldering infection. Mobility is preserved by the subperiosteal removal of the distal phalanx which leaves the extensor and flexor tendons attached to the periosteum. Sensibility is supplied by the undisturbed neurovascular bundles.

This results in a more congruous, nailed fingertip which is slightly smaller than normal but painless and useful.

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Florida Special Olympics Statement of Purpose

The ultimate goal of the Special Olympics Program is to create opportunities for sports training and athletic competition for all retarded children.

Recent scientific research has shown that physical activities, sports and competitive athletics are a major means of reaching the retarded. Here is an area where he can succeed and start building a positive self-image, gaining confidence and self-mastery as well as physical development. As a child improves his performance in the gymnasium and on the playing field, he also improves his performance in the classroom, at home and eventually on the job.

It is our hope that the Special Olympics Program will serve as a motivational "framework" within which physical education, recreation and sports activities can take place. Specifically, we are striving to:

(a) Provide motivation for the initiation of physical education and athletic programs where none exist.

(b) Provide supplementary materials which will aid those currently conducting such programs.

(c) Provide opportunities for athletic competition through local, state, regional and international Special Olympics.

(d) Give each retarded child a "feeling of belonging" by offering him membership in a national athletic club with membership certificates, periodic newsletters, etc.

(e) Instill in the retarded child a "sense of pride" by giving him a chance to win an award, be honored at a school assembly, or have his picture in a newspaper . . . by giving him a chance to know success.

April 21-May 6—Regional Games to be held on any day within this period.

June 2-3—STATE OLYMPICS GAMES in Tampa.

August 13-18—National Olympics Games in Los Angeles.

Any physician interested in an appointment as a member of the Medical Advisory Committee for their region should contact Dr. T. (Skeeter) Norley, 528 Northwood Rd., West Palm Beach, Florida 33407.

Carcinoma of the Vulva

James W. Daly, M.D. and David S. Bard, M.D.

Previously we reported our experience with carcinoma of the vulva.[1] In the intervening years, a staging scheme has been devised; the extent of surgery with regard to node dissection has been clarified to some extent, and the size of the study population has increased.

The present communication is a follow-up of the previous report and also represents current philosophy regarding therapy of vulva cancer in this Department.

Material and Methods

Forty-four patients with malignant vulvar disease have been seen at the W. A. Shands Hospital from January, 1959 to December, 1970 (11 years). There were 38 with squamous carcinoma of the vulva, three with cancer in situ of the vulva and one each with melanoma, Paget's disease and basal cell carcinoma.

The records and follow-up data on all patients were complete and subject to analysis. Those with squamous carcinoma of the vulva were staged in a retrospective manner using the classification system devised by the International Federation of Gynecology and Obstetrics[2] (Table 1).

The 38 patients with squamous cancer fall into three categories:

a. Twenty were treated prior to January 1, 1968. Their survival data will be presented in detail since this series allows for at least a three year follow-up. Franklin and Rutledge[3] report that 93% of deaths due to malignant vulvar disease occurs before the end of the third post-treatment year.

b. Twelve patients were treated after January 1, 1968.

c. Six patients had recurrence and/or were classified as inoperable.

Results

Epidemiologic Data

Most of the patients were parous and Caucasian. Although vulvar cancer is considered a disease of the senescent years (more common after the fifth decade), it is of interest to note the ages of the 32 patients treated primarily for squamous cancer (Table 2). More than half were less than 60 years of age.

An interesting correlation with other lower tract epithelial malignancies was found and is shown in Table 3. Forty-one percent had other tumors; one patient has survived three separate primary malignancies—vulva, cervix and gastric.

In 65% of the study population, there was prior and/or concurrent skin disease of the vulva, a figure which is probably low and due to under recording. Clinical leukoplakia was found in over one half (56%) and lichen sclerosis et atrophicus, granulomatous vulvitis, and condyloma accuminata were recorded on single occasions. All these skin conditions had existed from months to years, usually the latter.

Symptoms

All patients had pruritus vulvae, although of varying degrees. In many this was the presenting complaint. Next in order were a mass or ulcer (31%), bleeding (25%) and pain (22%).

Review of the charts reveals two points worthy of mention. Firstly, it is amazing how long an elderly female can conceal an obvious vulvar cancer. Patient delay is the rule rather than the exception. Secondly, once physician contact was made, nonspecific therapy often was instituted for varying periods of time prior to biopsy of the vulvar lesion.

Treatment

The therapy employed in the 32 patients who were considered operable is shown in Table 4. Further mention of current thoughts regarding the therapeutic regimen shall be discussed later.

Survival Data

As stated earlier, only 20 individuals qualify for detailed analysis, i.e., they allow for at least a three year follow-up. The material is summarized in Table 5. Three patients (15%) died of vulvar malignancy; each had a local recurrence. Five patients (25%) died of intercurrent disease

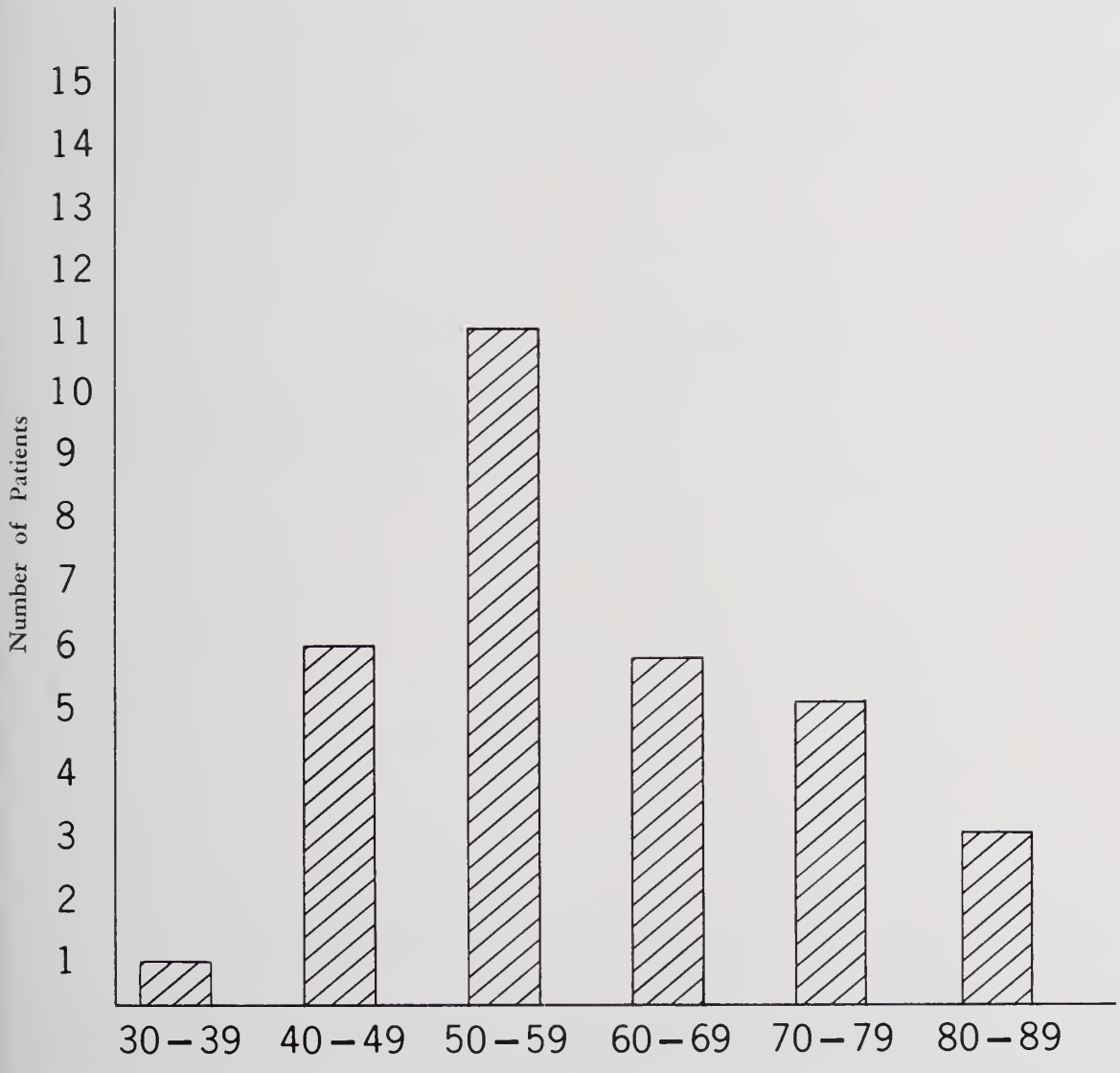
From the Division of Oncology, Department of Obstetrics and Gynecology, University of Florida College of Medicine, Gainesville.

This research was supported in part by the American Cancer Society.

Table 1.—Cancer of the Vulva—Clinical Staging.

STAGE I	Tumor confined to the vulva with a maximum diameter of 2 cm. or less and no suspicious groin nodes
STAGE II	Tumor confined to the vulva with a diameter greater than 2 cm. and no suspicious groin nodes
STAGE III	Tumor of any size with adjacent spread to the urethra/vagina/perineum/anus—or with suspicious groin nodes
STAGE IV	Tumor of any size infiltrating the bladder mucosa/rectal mucosa/upper ⅓ urethral mucosa/fixed to bone/distant metastasis—or with fixed or ulcerated groin nodes

Table 2.—Cancer of the Vulva—Age at Diagnosis.



with no evidence of tumor. The determinate survival is 12/15 patients or 80%.

Between 1968-1970, an additional 12 subjects have been seen. At present, nine are alive and three are dead. One patient died of cancer of the mouth and two of vulvar malignancy, nine and 14 months after therapy and with local and/or pelvic recurrence.

The final category consists of six individuals with recurrent or inoperable disease. Four are dead and two survive. The following regimen was employed in this series:

a. no treatment —1
b. chemotherapy —2
} dead within 6 months

c. palliative colostomy, ileal conduit —1
} dead at 48 months

d. anterior exenteration, vulvectomy with node dissection —2
} alive at 17 and 48 months

Discussion

From the data we have collected, it is apparent that present surgical management is effective in controlling carcinoma of the vulva. It is obvious also that the smaller, earlier lesions are associated with a much better chance of cure.

In every cancer operation, local recurrence is a problem. In view of our 15% incidence, a more aggressive approach has been instituted in the removal of the vulvar area and surrounding skin. Further, in an attempt to prevent or minimize tumor implantation at the operative site, an additional procedure has been used. The site of the excised lesion is covered with gauze (sponge or pad) and is sutured in place. The gauze is then soaked with a 10% formalin solution.

Pelvic lymphadenectomy was performed—in conjunction with vulvectomy and groin dissection —in 15 patients. But only two were found to have cancer in the nodes. Accordingly for the past several years pelvic node dissection has been

Table 3.—Cancer of the Vulva—Other Tumors.

LESION	TIME RELATIONSHIP TO VULVA THERAPY		
	BEFORE	CONCURRENT	AFTER
Cancer in situ Vulva	1		
Cancer in situ Cervix	2	1	
Invasive cancer Cervix	4		1*
Skin	2		
Gastric			1*
Oral cancer			1
Multiple myeloma			1
	9	1	4

*Same patient

Table 4.—Cancer of the Vulva—Treatment.

METHOD	NUMBER
Vulvectomy	1
Vulvectomy with radiation to nodes	1
Vulvectomy and groin dissection	14
Vulvectomy and groin dissection and pelvic lymphadenectomy	15
Vulvectomy and node dissection and removal of rectum	1
	32

Table 5.—Cancer of the Vulva—Survival Data.

CLINICAL STAGING	ALIVE	Dead of CA	DEAD OF INTERCURRENT DISEASE	DETERMINATE SURVIVAL (col.½	%)
STAGE I	3	0	1*	(3/3	100%)
STAGE II	7	2	2	(7/9	78%)
STAGE III	2	1	2	(2/3	66%)
	12	3	5	(12/15	80%)

*Postoperative death.
Data pertains to patients treated 1959-1967.

omitted except in those instances where positive inguinal nodes are identified. Stated in other words, primary surgical management consists of vulvectomy and bilateral groin dissection. Franklin and Rutledge[3] come to the same conclusion for two principal reasons: (1) Pelvic node metastasis is almost invariably preceded by groin metastasis; and (2) When pelvic nodes are positive, the survival is very small and must be weighed against the individual operative risk.

Since carcinoma of the vulva appears to develop in a stepwise fashion locally and then to regional nodes, very radical surgical procedures appear to be indicated in selected patients. Three exenterations (2 posterior, 1 anterior) have been performed; the patients are alive at 12, 48, and 120 months respectively. The point to be made is that very extensive surgery is part and parcel of the therapeutic approach, albeit an uncommon one.

Conclusion

We have noted the relationship between invasive squamous cancer and other epithelial neoplasms in the genital area. This finding is not an isolated one; the subject has been reviewed by Jimerson and Merrill.[4] As a result, all patients treated for genital tract epithelial malignancy are to be followed for life; the entire genital area is to be evaluated at each follow-up visit.

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Increased Incidence of Hyperthyroidism in the Cuban Population of Greater Miami

Fuad S. Ashkar, M.D., Robert Miller, M.D., George Jacobi, M.D., and J. N. Naya, M.D.

Since Parry described the syndrome of hyperthyroidism in 1825, the etiological significance of emotional shock has been stressed by many clinicians.[1]

The increased incidence of hyperthyroidism due to war has been pointed out since the Franco-Prussian War.[2] Accordingly, the Second World War caused a transient rise in the frequency of hyperthyroidism in Denmark, Belgium, Holland and Norway.[3, 4]

Spaulding showed that there was an increased incidence of thyrotoxicosis in immigrants in Canada in 1963.[5] The immigrants were of European origin and had four times the rate of native born Canadians.

The etiology of Graves' disease is as much an enigma today as it was at the turn of the century. Although there is no doubt that we have progressed far in the understanding of this disease with the advent of radioimmunoassay of thyrotropin (TSH) and the discovery of the long-acting thyroid stimulator (LATS), the fundamental cause of thyrotoxicosis remains unknown.

The greater Miami area offers a unique opportunity to study the effects of stress on the Cuban people and to record and compare the incidence of hyperthyroidism among them to the non-Cuban population of the same area.

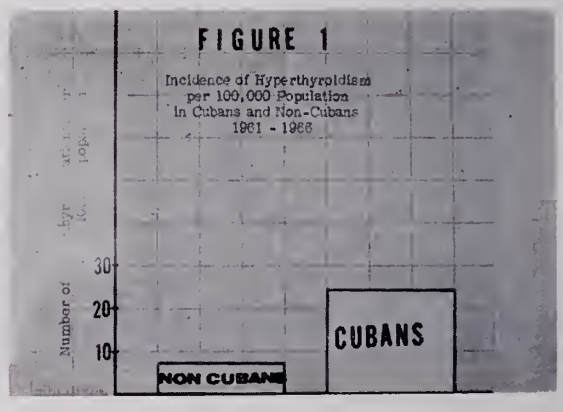
Following the Communist revolution a decade ago in Cuba, mass migration of refugees to the greater Miami area occurred. Long range difficulties and major steps in social adjustments were encountered in this move. Subsequently, many of these refugees were found to develop hyperthyroidism.

The incidence of the disorder in the greater Miami area as seen at Jackson Memorial Hospital, the Dade County Metropolitan hospital and University of Miami staff hospital, was studied for the years 1961 to 1966 for both the non-Cuban and Cuban population.

Clinical Data

The average yearly total non-Cuban population in the greater Miami area was 975,728 while the average number of Cubans during the same period was 84,000, a ratio of 11.5:1.[5] The ratio of the non-Cuban admissions to the Jackson Memorial Hospital to that of Cuban admissions was 10.6:1 (Table 1).

The average yearly number of hyperthyroid patients seen during this same period for the non-Cuban group was 79 while the Cuban group consisted of 21 patients, a ratio of 3.7:1.[6]



From the Division of Nuclear Medicine, Department of Radiology, and the Department of Medicine, University of Miami School of Medicine, Miami.

Table 1.—Hyperthyroidism in Non-Cuban and Cuban Population of Greater Miami, 1961-1966

	Non-Cubans	Cubans	Non-Cuban to Cuban Ratio
Miami average yearly population	975,728	84,600	11.5:1
Hospital admissions percentage	92	8	11.6:1
Mean age	27	28	1:1
Hospital insurance availability %	67	72	1:1
Indigent patients %	30	34	1:1
Hyperthyroid average yearly admissions	79	21	3.7:1
Hyperthyroidism per 100,000 population	7	24	1:3.4
Hyperthyroidism males to females	1:4	1:3.8	1:1
Hyperthyroidism mean age	37	35	1.1:1
Hyperthyroidism diffuse/nodular	4/1	9/1	1:2.2

The diagnosis of hyperthyroidism was made by a clinical evaluation combined with elevated thyroid function tests (PBI, BEI, RAIU, T_3, T_4).

The incidence of hyperthyroidism per 100,000 population in the non-Cuban group consisted of 7 while the incidence in the Cuban group per 100,000 population was 24, a ratio of 1:3.4 (Fig. 1).

In 1961 to 1966 20% of male hyperthyroid patients seen were non-Cuban compared to 21% Cuban; 80% of females non-Cuban compared to 79% Cuban.

In 1961 to 1966 diffuse nontoxic goiter occurred among the non-Cubans at the rate of 79% and among the Cubans at a rate of 90%. The rate for nodular toxic goiter for this period was 21% for non-Cubans and 10% for Cubans (Table 1). These types of goiter were separated on the basis of clinical evaluation and appearance of the thyroid scans.

The non-Cuban and Cuban population studied had a comparable age, socioeconomic status and hospital admission rate (Table 1).

Comments

These figures show that the incidence of hyperthyroidism in the Cuban population is three and a half times that of the non-Cuban population of the greater Miami area in the period 1961 to 1966 as seen at Jackson Memorial Hospital, where there was no significant difference in non-Cuban to Cuban medical admissions to their ratio in the general population.[7]

The other significant finding is a relative increase in the incidence of diffuse toxic goiter in the Cuban population versus the non-Cuban population. There is no significant difference in hyperthyroidism sex distribution between the two groups.

This high incidence of hyperthyroidism in the Cuban refugees is comparable to the increased incidence reported by Spaulding in immigrants to Canada.[5] The incidence as reported in various series in Latin American populations not under stress is low (de Leon in Dominican Republic and Gomez A. Fanador in Colombia) and does not compare to the high incidence in Miami.[8]

Summary

Numerous authors have noted the significant etiological role of stress and emotional shock in the induction of hyperthyroidism. An increased incidence of this disorder was found in recent Cuban immigrants in the greater Miami area. The observed frequency was three and a half times that of the non-Cuban population.

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Dr. Ashkar, University of Miami School of Medicine, P. O. Box 875, Biscayne Annex, Miami 33152.

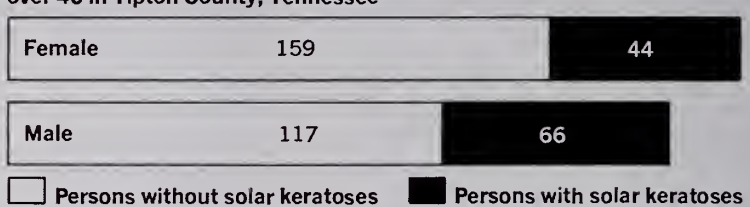
What it means to live and work in Tipton County, Tennessee

Persons who are white and over 40 have one chance in four of having solar keratoses... which may be premalignant

An epidemiologic study* conducted in Tipton County, Tennessee, revealed that 28.5% of white persons over 40 had solar keratoses; most had multiple lesions. Cluster sampling projected an estimated prevalence of 32.5% for white males and 19.5% for white females.

Though this is an unusually high percentage of affected persons, these lesions can occur in any white population, wherever people work or play out of doors.

Prevalence of solar keratoses in white persons over 40 in Tipton County, Tennessee



*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.



Solar, actinic, senile keratoses

Called by many names, the typical lesion is flat or slightly elevated, brownish or reddish in color, papular, dry, adherent, rough, sharply defined; usually multiple lesions, chiefly on exposed portions of the skin.

Sequence/selectivity of response

Erythema in areas of lesions may begin after several days of therapy; height of reaction (only in affected areas)* usually occurs within two weeks, declining after discontinuation of therapy. Since this response is so predictable, lesions that do not respond should be biopsied to rule out the presence of a frank neoplasm.

Cosmetic results

Cosmetic results are highly favorable. Incidence of scarring is low—important with multiple facial lesions. Efudex should be applied with care near the eyes, nose and mouth.

5% cream–a Roche exclusive

Only Roche formulates the 5% cream... high in patient acceptability... high in clinical efficacy, especially for lesions of hands and forearms... economical.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

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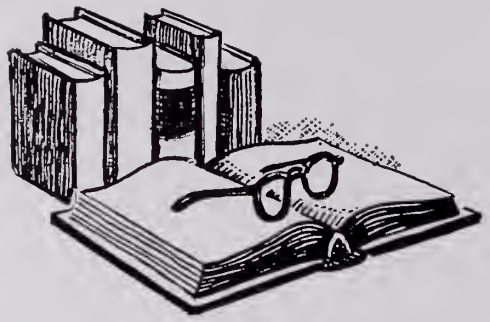
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Book Review

Management of Juvenile Diabetes Mellitus, Second Edition by Howard S. Traisman, M.D. Pp. 223. 62 illustrations. Price $19.75. St. Louis, The C. V. Mosby Company, 1971.

This book presents the salient features of diagnosis and care of the diabetic child. As acknowledged in the preface, approaches to the management of this difficult problem are varied and the author's experience alone is presented.

This relatively short book (less than 200 pages exclusive of appendixes) is written in outline format with subsections in each chapter introduced by appropriate spacing and bold type. Photographs, diagrams, and illustrations are plentiful, but bibliographies following each chapter are brief.

In addition to general information regarding epidemiological, pathophysiological, and pharmacological material, recommendations for treatment of specific problems are presented. A lengthy chapter on dietary management containing numerous practical suggestions may have been improved by omitting many sample diets. They are available elsewhere. The various insulins are well reviewed; this discussion and the excellent chapter on the management of diabetic acidosis are probably the highlights of the book. This text may well be added to the physician's other volumes concerning diabetes mellitus to help prepare him in the handling of this complex problem.

Harry W. Eichenbaum, M.D.
St. Petersburg

Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

Synopsis of Pediatrics by James G. Hughes, M.D. Pp. 1141. Illustrated. Price $14.50. St. Louis, The C. V. Mosby Company, 1971.

Current Concepts in Dyslexia edited by Jack Hartstein, B.S., M.D. Pp. 212. 34 Illustrations. Price $12. St. Louis, The C. V. Mosby Company, 1971.

Approach to the Medical Care of the Sick Newborn by Sophie H. Pierog, M.D. and Angelo Ferrara, M.D. Pp. 292. 42 Illustrations. Price $11.50. St. Louis, The C. V. Mosby Company, 1971.

Biochemical Profiling in Diagnostic Medicine by Joseph A. Preston, M.D. and David B. Troxel, M.D. Pp. 51. Price $2.50 for set of five. Tarrytown, New York, Technicon Instruments Corporation, 1971.

CRC Manual of Nuclear Medicine Procedures by William H. Beierwaltes, M.D., John W. Keyes Jr., M.D. and James E. Carey, M.S. Pp. 137. Price $19.90. Cleveland, Ohio, CRC Press, 1971.

Cardiovascular Physiology, Second Edition, by Robert M. Berne, M.D. and Matthew N. Levy, M.D. Pp 265. 193 Illustrations. Price $9.25. St. Louis, The C. V. Mosby Company, 1972.

The Pediatric Nurse Practitioner by Fernando J. deCastro, M.D. and Ursula T. Rolfe, B.A., M.D. Pp. 154. Illustrated. Price $6.50. St. Louis, The C. V. Mosby Company, 1972.

A Primer of Electrocardiography by George E. Burch, M.D. and Travis Winsor, M.D. Pp. 292. 287 Illustrations. Price $7.75. Philadelphia, Lea & Febiger, 1972.

Special Articles

A Summer in Afghanistan

Marvin Burdette Jr., John Atkinson and Henry Anderson

If anyone had told any one of us last May that in less than four weeks all three of us would be in Afghanistan, we never would have believed it. The three of us, senior medical students from the Universities of Florida, Washington, and Wisconsin, accepted the opportunity to spend two months there, sponsored by the Medical Assistance Programs, Inc.* MAP, headed in Afghanistan by Drs. Rex and Jean Blumhagen, was working for the summer with Drs. James Duke and Andrew Stenhouse, professors at Nangarhar University Faculty of Medicine and members of the Indiana-Loma Linda universities Consortium Team. Our purpose in going was to help conduct a health survey and assist in providing medical care in the central mountainous region known as the Hazarajat.

We arrived in the capital city of Kabul in late June and were greeted by a dry, dusty and hot climate despite the 6,000 feet elevation. Afghanistan itself is a land of extremes, from the rugged peaks of the Hindu Kush to the blistering Khash desert. Known as the crossroads of Asia, it is a land-locked country between Russia, Iran, and West Pakistan, an area traversed in history by such armies as those of Darius, Alexander the Great, and Genghis Khan. Today some of the nomadic tribesmen still follow the same trails as did Marco Polo in the 13th century.

Survey and Clinical Duties

Our first week was spent in Kabul in class trying to master a few of the basics of the Persian language. Then we departed for our base camp, Naiak, a small village located about 200 miles from Kabul in the Hazarajat mountains. The Afghan government and MAP selected this area, first, because there is essentially no medical care at all there for its estimated 2 million inhabitants and, secondly, because the population is ideal for long-term studies which could be very significant in planning future programs of preventive medicine and health care delivery.

The survey was to be both a longitudinal and cross-sectional type study. Our immediate goals were to determine the nutritional status before any variables were brought in, to ascertain the general incidence and type of disease, to learn local health and sanitation practices, and to learn such things as the percent of positive tuberculin

The authors are senior medical students. Mr. Burdette, University of Florida College of Medicine; Mr. Atkinson, University of Washington, and Mr. Anderson, University of Wisconsin.

*Medical Assistance Programs, Inc., is a secular, nonprofit organization which sends medical supplies overseas to 1,000 physicians and dentists sponsored by more than 125 mission boards. MAP whose headquarters are in Wheaton, Ill., is financed by donations. The MAP team in Afghanistan is the first medical team sponsored.

skin test, mortality causes, birth and infant mortality rates. We also wished to function as a mobile clinic to provide medicine for all those who required treatment. We were to lay the groundwork for subsequent monthly visits by doctors and nurses who would continue therapy and provide prenatal care, family planning information and public health instruction.

Two villages were chosen, both about an hour by jeep from the Naiak hospital, but in opposite directions and far enough from the hospital so that only a few people had been to the hospital. Both communities were subsistence agrarian and herding societies. There was no industry and the only cash income was from wool and, rarely, from excess wheat. These people have two homes, the main village where everyone wintered, and the eilocks which were higher in the mountains where the sheep were grazed in the summer and the winter fodder and fuel were gathered. To be able to examine 90-95% of the villagers as we wanted, we eventually had to transport the farthest people to our central survey site.

Our summer work was divided between the health survey and the outpatient clinic and hospital in Naiak. We were fortunate in having four Afghan senior medical students working with us, Abdul Hadi, Sayed Mohd. Yousuf, Nirmal Singh and Raqbeer Singh. These students from Nangarhar University were paired with us in teams to work on the survey or in the clinic and hospital. Their knowledge of the particular indigenous diseases was very helpful and the MAP team is indeed grateful to them for making the summer a cooperative effort. Other members of the MAP



Fig. 1.—12 year old boy with severe osteomyelitis of the tibia, who limped into the hospital unassisted. The large sequestrum was removed and his leg was debrided in the operating room. He was placed in a cast and treated with antibiotics.



Fig. 2.—10 year old girl with smallpox. Her vesicles are one week old.

team were a number of Peace Corps translators, British nurses, and German, Greek, Scandinavian, and Canadian workers.

After the village leaders' cooperation and understanding had been secured (only following hours of diplomacy, explanation, and the consumption of gallons of hot tea), the Peace Corps teams would spend several days mapping the villages, recording family relationships, land distribution, dietary habits, number of births, sanitation and health practices. They provided us with a past medical, social, and family history of each villager prior to their examination. There were two medical teams, one of women doctors since men are not allowed to examine women in their culture. The men's team consisted of one Afghan medical student, one of us, and one of the M.D.'s. We took turns on the survey team, working from standardized history and physical forms. We soon learned that parts of our exam were unreliable due to the fact that these people had never been seen by a doctor and were unfamiliar with what was expected of them. Such things as visual acuity, fundoscopic and neurologic examinations were major undertakings and were either abbreviated or eliminated. Reliable histories were difficult to elicit even with the help of the Afghan medical students. For example, "pain on urination" meant either dysuria or hemorrhoidal pain. Moreover, many Afghans had difficulty in distinguishing between sickness and health as westerners define it. Some would complain of palpitations after carrying a heavy load up a mountainside or of leg pain after walking several days. But the people as a whole are very stoic and may not come into the clinic until their disease is so far advanced that they are unable to work.

As part of the survey we had a trained lab technician. Urine dipsticks, stool exams, hemoglobin, hematocrit, total protein and VDRL's were routinely done on every patient. When called for, they could do white blood cell and differential blood counts, cold agglutinins, gram stains and acid fast stains, and TB cultures. In the second village we also took samples for random vitamin A and D assays.

Most of the results are still being compiled by the permanent staff in Afghanistan. These data will be formally published when analysis is completed. We had seen little malnutrition or vitamin deficiency—an unexpected result. The most prevalent diseases were trachoma and allergic conjunctivitis, enteric parasites, bronchitis and URI's, measles in children, and tuberculosis and leprosy. Venereal disease was nonexistent in these rural people. Anemia was uncommon, although we were not sure of the normal range for these people living at 8 to 10,000 feet elevation.

Polyclinic

In addition to the survey all of us worked in the "polyclinic" and in the newly completed 20 bed hospital with a modern, well-equipped operating room. Clinic was held three days a week and generally ran well over a hundred patients, who presented with anything from ascariasis to severely



Fig. 3.—Group picture: the medical students making rounds on a patient with typhoid. Left to right are Marvin Burdette, Nirmal Singh, John Atkinson, Sayed Mohd. Yousuf, the patient's husband, Andy Anderson, and Abdul Hadi.



Fig. 4.—Baktawari. A 15 year old boy with a two week old ruptured appendix. One week postoperative.



Fig. 5.—45 year old man with leprosy—lepromatous type. Note the absence of eyebrows and the depressed nasal bridge.

crippling Pott's disease. Common problems included abscesses, cellulitis, trachoma, parasitic infestation, arthritides, fractures, hernias, bladder stones (a high incidence in young males), and a broad spectrum of tuberculosis—of the lung, spine, peritoneum, kidney, lymphatics, joints, epididymus, and skin. Somewhat less common, the estimated prevalence of leprosy was 1% to 2% and was primarily the lepromatous type.

The majority of patients admitted to the hospital were admitted through the clinic. One such patient was a 45-year-old lady complaining that two years previously she had become pregnant but the "baby just never came." At surgery the preoperative diagnosis of ovarian cyst was confirmed and she recovered uneventfully after removal of the 20 lb. tumor.

Another patient was a 25-year-old man who was being brought in on camel-back when Dr. Blumhagen found him while returning from a nearby village. This Afghan was admitted to the hospital with signs and symptoms of an acute abdomen. He gave a history of vague abdominal pains and general malaise for two years with a severe, acute episode accompanied by fever, nausea and vomiting one year before. At laparotomy 5 liters of fluid and fecal material were removed. Extensive hydatid cysts covered the bowel and mesentery—the worst case of echinococcosis Dr. Duke stated he had ever seen. Despite drainage, antibiotics, fluid and electrolyte replacement, the patient died the following morning from overwhelming sepsis. In retrospect, the echinococcus plastic peritonitis probably occurred as a result of a ruptured hepatic cyst one year prior to admission, and when we saw the patient he had a perforated appendix which could not be walled-off adequately by the already-fused peritoneal contents.

Another case of a ruptured appendix was a 15-year-old boy named Baktawari who was brought in more than two weeks after the appendix had ruptured. He also required four quadrant drainage and single layer wire closure. Following surgery we employed a modern method of nutritional supplement, a special amino acid preparation to treat his marked inanition. A month after we returned, we received word that Baktawari had fully recovered and gone home.

During the summer three cases of smallpox were brought to us. The incidence of smallpox has declined since the Afghan government began a vaccination program, but the disease is not yet

under control, especially in the more isolated areas such as the Hazarajat. One 7-year-old boy named Assan Shah was brought in about the ninth day of his illness. He had 5-7 mm umbilicated vesicles over his entire body, more pronounced on his trunk and face. We treated him in isolation with fluid and electrolyte maintenance, penicillin via nasogastric tube and applied penicillin ointment for the conjunctivitis. Over the next week the lesions progressed to gold crusted areas and on the fifth hospital day he began to improve as evidenced by an increased appetite and awareness of his environment. At ten days he had defervesced and the eschar was removed easily from his lesions leaving a red weeping epithelium. On the next day he was discharged.

Conclusion

It was very rewarding to see Assan go home, as it was with many of the others whom we treated. In two short months the three of us had seen and treated diseases we could never have seen in our own university hospitals. We had the opportunity to live and work with the four Afghan students, to exchange thoughts and ideas on patient care and delivery of medical care.

We began to see some of the immense problems in medical care in a developing country, particularly the immense importance of preventive medicine. For instance, BCG vaccination would go a long way toward reducing the ravages of tuberculosis in Afghanistan. However, the smallpox vaccination program alone takes up almost the entire budget of the Ministry of Health.

Our experience also helped us gain perspective on our own health care systems and to appreciate the advanced diagnostic facilities available at home. Many times we experienced the frustration of not having a badly needed x-ray, laboratory test, or even the choice antibiotic which had just run out. During the summer we learned to sharpen our clinical diagnostic abilities and clinical judgment because we had to rely mainly on clinical diagnosis and therapeutic trials in many instances. Even with the given limitations, we were pleased to see just how much the MAP project had accomplished and is continuing to accomplish in Afghanistan, and all three of us would welcome the opportunity to return there someday.

▶ Mr. Burdette, 1700 Southwest 16th Court, Gainesville 32601.

What then is the spirit of liberty? I cannot define it; I can only tell you my own faith. The spirit of liberty is the spirit which is not too sure that it is right. The spirit of liberty is the spirit which seeks to understand the minds of other men and women. The spirit of liberty is the spirit which weighs their interests alongside its own without bias. The spirit of liberty remembers that not even a sparrow falls to earth unheeded. The spirit of liberty is the spirit of Him who, near two thousand years ago, taught mankind that lesson it has never learned, but has never quite forgotten: that there may be a kingdom where the least shall be heard and considered side by side with the greatest.

JUDGE LEARNED HAND

I Believe 1972

Philip B. Phillips, M.D.

Who Cares What I Believe? More important is what do you believe? Have you ever tried to record your political, economic, religious, international and other uneasy feelings to see how you as an American citizen stack up in 1972? Perhaps this lack of introspection is why so many fail to take an active part in the decision-making in this country. Do your legislators represent you? Do they know what you think? If democracy is to be effective and to survive, then your representatives should vote the will of the majority. How can they, if you do not share your feelings with them?

Once America was the greatest country in the world. Today we are often the laughing stock of too many countries. Our dollar has been devalued, our gold stores are depleted and our people are disenchanted. Our military posture is pathetically deteriorating and too many of our reluctant military personnel are lost in a fog of pot fumes or on a heroin freakout.

I believe that union labor leaders' domination of our American congress could push this country into bankruptcy and into a third rate position in international trade and that the political ambitions of some "super liberals" are a serious threat to the moral integrity of this country and it may already be too late.

I believe that President Nixon is making a sincere effort to be a competent national leader, but that he is often stymied by a Democratic-controlled congress, many of whom seem to be running for his office and too many of whom are subject to pressures from organized labor, the leaders of which are more self-centered than statesman-like.

The center cities are decaying, the ghettos spawning addiction and crime and the urban politicians screaming for more money. In the absence of good public transportation, cars are choking our cities to death with stalled traffic and stagnant exhaust fumes. Only the economically trapped and the helpless remain. Honest men and women are warned from the streets of our cities, if they would protect their persons and their property.

Some cities are so decadent and dilapidated as to warrant abandonment with new ones to be built in their places. A massive federal housing program leading to private ownership might in time eliminate the rat-infested ghettos of some of our eastern cities. Somewhere in this once great land, there must be millions of God-fearing, decent, perceptive people who vigorously deplore the decadence at their doorsteps.

I believe that if religion were the only salvation of our country, then Reverend Billy Graham and others would have the answer. Perhaps the innate sense of fair play and the strict standards of right and wrong, which most good Americans were taught as children and which they still hold deep in their hearts, may in time offer some hope for a national revival. A wider awareness of the ultimate evils of selfishness might initiate a move toward action that would reflect our interpersonal dependence.

I believe that public morality is almost as questionable as private morality. Fortunately, not all business is controlled by organized crime —yet, inroads in this direction are being made. Not all dishonest politicians have been apprehended, though progress is occasionally made. The lawbreakers laugh at enforcement officers and the public too often fears "getting involved." The courts have lost much of their prestige and effectiveness due to the inadequate number of judges, the inadequate funding of courts by legislative bodies and the resulting interminable delays in bringing cases to trial. The decisions and interpretations of the Warren court were destructive of our public respect for law and order. Law abiding people become the downtrodden and the disadvantaged.

I believe that our involvement in Vietnam was unwise and outside our basic interest and inexcusable to the parents and loved ones of the men lost there unnecessarily. It has been the most politically doubtful international involvement in our country's history, the most unaggressively

waged and almost unbelievably costly in money, pride and international stature.

I believe that health is not necessarily a "right," but a privilege for those willing to seek health through intelligent utilization of preventive measures. Excessive eating, excessive drinking, speeding and overworking are personally chosen excesses which could be controlled by the guilty if they chose. Health insurance can be bought and should be by those who seek good health. The government has a proprietary interest in the health of its citizens. The Medi-Credit bill sponsored by the AMA would make medical care available to the public through income tax concessions at a price they can afford through the existing health insurance industry. Catastrophic coverage is properly included. Promises of cradle-to-the-grave security at the full expense of the government are fiscally seductive but philosophically ridiculous. I believe that the right to choose an abortion is every woman's private medical decision to be made in consort with her husband, her family, and her physician. I believe in the sterilization of women bearing more than two illegitimate children.

I believe that moralists who decry and oppose capital punishment are inadvertently contributing to the spread of crime and to our national moral deterioration. I believe that murder, rape, torture and armed robbery, should be punished promptly by death within weeks after guilt is established according to the laws of the state in which the crime was committed. I believe in the right of every man to possess firearms for the protection of his home and family and in his right to defend his person and property against forceful intruders.

I believe in equal rights for men of any color or creed based on their abilities and their desires, and in equal rights for women, equal salaries, and equal opportunities for advancement, dependent upon their demonstrated abilities. I believe in the rights of private social organizations to determine who may and who may not affiliate in membership based on the will of the majority of the members.

I believe in families having the right to send their children to schools of their own choice, that catholics should have their fair share of tax money if they choose to run their own schools and that parents should be allowed tax credit certificates if they wish to send their children to private schools for a superior education. I believe that moderate corporal punishment of delinquent school children up through Junior High age, administered under the supervision of responsible school authorities, might help wayward youngsters in their "personal adjustment." I believe that admission to college is a privilege, not a right, and that entrance requirements should be raised appreciably and that loan funds should be ample so bright students are not denied their opportunities. I believe that vocational education is one of the most neglected areas of training in contemporary America and that it offers an outstanding opportunity for improvement in the standard of living. I would prefer more expert plumbers, electricians and electronic technicians and fewer experts on the love life of the bumble bee or critics of Greek poetry. I believe that cross-country bussing to achieve some fancied mathematical averages of racial groups is an expensive, ridiculous and unnecessary idea which could have originated only in the minds of political appointees, federal judges or HEW employees, not responsive to the electorate.

I believe that the evils of marijuana have probably been overrated and thus "pot" has had more than its fair share of advertising. With less to do, it would lose its attraction to the young. I believe that heroin pushers should be hanged or electrocuted promptly upon conviction as an indication of their real menace to society. I believe that pornography is much ado about nothing, that its effect on people is variable and that vigorous denunciation simply advertises.

I believe that we gave away billions in a desire to buy friends and we gained little from our generosity. Honest loans to countries willing to help themselves would not have alienated the recipients.

I believe that confiscatory, constantly escalating taxes strangle the industrious to support the indolent. Welfare doles to the physically and mentally fit are a form of theft, politically contrived and nurtured by a nationwide pressure group of do-gooders who frankly have an obvious conflict of interest. I believe that veterans compensation for "total disability" has reached the point in generosity that it is difficult to motivate those obviously not disabled veterans to give up their sinecures and return to productive work, since their "checks" often exceed any earnings they ever knew. Truly disabled veterans from war time service can never be compensated adequately.

I believe in "vested" retirement plans, so workers take their retirement rights with them as they progress from job to job and that farm subsidies and payments for not growing crops when widespread famine still exists in the world are "schizophrenic" economics and is chauvinistically uncompassionate. I believe that the 30 hour week is a flirtatious promise sung by a union siren which would lead to lesser production at increased cost, and since people often waste their weekends now, would probably lead to increased alcoholism, increased divorce and a greater highway death toll. In our society, work still is a significant status symbol, a gratifying thing through its daily reassurance of personal value, an ego-satisfier, often underrated until it is lost by disability or retirement.

I believe in so many of the fine aspects of our country and the deep down goodness of our people but I hate to see our deterioration insidiously continue. I believe that the seemingly archaic virtues of hard work, honesty, loyalty, cooperation with one's neighbors, personal responsibility and integrity, respect and adherence to the "golden rule" and a willingness to put the welfare of society above the individual's selfish goals, would do a lot toward restoring a higher international stature for this country and would radically enhance the internal qualities of our society. Is it really too much to ask that we produce as much as we receive in rewards? That we treat our fellowman of any color with respect and equitably? That we keep a tight rein on our innate selfishness and that we quit trying to be loved by all nations for our dubious generosity? It isn't too much to ask, but it is nearly too late! Otherwise, we leave to our descendants only our regrets.

I believe that you may wonder what sort of person would expound so many controversial ideas for others to reflect upon. Middle western, middle aged, middle income, multiple degrees, military service in two wars and multi decorations, sons in college, a politically astute wife, a demanding profession, yet time for many hours of community and charitable efforts, a relatively limited life expectancy, but with a deep love of country, a proud heritage and the belief that modern man must ask seriously, "Whither goest thou?"

▶ Dr. Phillips, 1515 West Moreno at "K", Pensacola 32501.

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Restaurants of the Gold Coast

Charles A. Monnin Jr., M.D.

There is more to a convention than meetings, as we know. Now, let's discuss the wining and dining. Here is a list of a few of the restaurants that many of my colleagues and I have found most enjoyable.

Some restaurants are large, some are small but we have tried them all. A few we did not mention for various reasons. (Would you believe *some* are closed!).

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*Diplomat—Celebrity Room—French food. The Maitre d' is James A. Morrison who specializes in Veal Oscar and Bouillabaisse Marseillaise.
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La Normandie Restaurant (Headquarters of Les Ami du Vin) 129 North Federal Highway, U.S. I, Dania, Fla.
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*Dome of the Four Seasons. In north Ft. Lauderdale. Maitre d' Pierre. Wine cellar insulated with 18″ of cork on all four sides, top and bottom.

Venetian Room on top of the Sheraton Hotel in Ft. Lauderdale is excellent in both food and atmosphere.

Moonraker located on an inland waterway is superb steak house with an unusual atmosphere and *excellent* wines.
3001 East Oakland Park Blvd.
Ft. Lauderdale
Phone: 563-1211
Warren E. Foster, owner

The Down Under across from the Moonraker is an interesting restaurant. (Again you are on the waterfront).

Cafe de Paris is a small French restaurant in Ft. Lauderdale.
715-A East Las Olas Blvd.
Phone: 523-2900

Cafe de Beaujolais in Ft. Lauderdale is a small French restaurant.
34 N.E. 9th Street
Phone: 566-1416

Mai-Kai-Cantonese Cuisine. Famous for rum drinks and floor show.
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1200 North Federal Highway
Ft. Lauderdale
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Now let's travel more in the Miami Beach area

*Fontainebleau—Club Gigi. The Host Manager is Andre Pascal. A most eloquent atmosphere for wining, dining and dancing.
54th and Collins Avenue
Miami Beach
Phone: 538-8811

*Bernard's Carriage House Restaurant. Mr. Bernard and Executive Chef Heinz Warich offer a varied continental menu.
54th and Collins Avenue
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Phone: 864-4804
Reservations are a must. Open daily 11 a.m. for lunch; 6:30 p.m. for dinner, except Monday.

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9650 East Bay Harbor Drive
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Prince Hamlet. Famous for Danish cuisine.
8301 Biscayne Blvd.
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Raimondo's is another exceptional Italian dining room where food is cooked to order (do not hurry). Famous for its classical Italian recipes.
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Valenti's Italian Cuisine is well known to all who have passed through the thresholds of Jackson Memorial Hospital.
Phone: 379-7661

Miami Springs Villas. Take your choice of any of 17 dining rooms. Among the best known are The Japanese Steak House and King Arthur's Court (with its strolling violins).
500 Deer Run
Miami Springs
Phone: 871-6000

Chez Vendome of the David Williams Hotel. The chef is Eric Jorganson.
700 Biltmore Way
Coral Gables
Phone: 443-4646

Cuban restaurants noted for their colorful floor shows and excellent Latin cuisine.

Les Violins
1751 Biscayne Blvd.
Phone: 371-8668

Flamenco Supper Club
991 N.E. 79th Street
Phone: 751-8631

ABOUT THE AUTHOR: Apart from being the Bailli of Florida and Greater Miami, Confrerie de la Chaine des Rotisseurs, he is also a member of the Physicians' Wine Appreciation Society, etc. Recently he was a judge of culinary arts in Budapest, Hungary. He is also a Compagnon de Bordeaux and a member of Les Ami du Vin.

▶ Dr. Monnin, 250 Bird Road, Coral Gables 33146.

Reprints of this list of good eating places and Dr. and Mrs. Richard Fleming's "Rx For Prandial Pleasures," published in the April Journal will be available at the Registration Desk during the Annual Meeting.

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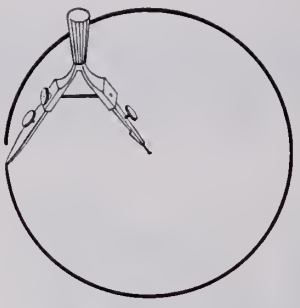
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Editorials

To Inform, Instruct, Educate

What is the function of the journal of a state medical association? Besides being a compendium in which constituent practicing physicians and those in local medical schools can publish their scientific papers, it should catalogue the history of regional medical heritage, list official proceedings of the association and provide intercommunication between members. Issues and solutions developed by our officers and the House of Delegates plus county societies' solutions to problems common over the state should be made widely known by publishing in monthly issues.

What is the purpose of an editor of a state medical journal? Besides encouraging every physician to try his hand at writing and to stimulate superiority in original medical composition, he is under a mandate to ever seek the truth, and should never indulge in that insidious form of brain washing which consists of denying space to those whose ideas conflict with his own. With help from a consulting staff representing the various specialties, it's easy to compose a letter, quoting the reviewer, to a contributor in accepting or rejecting his manuscript. It's frustrating to write someone, who has requested insertion of an essay or an announcement submitted past our deadline, that his copy came in too late. It's frustrating when one's best intention of finishing an editorial too often is put off to answer the telephone, to work at solo practice, to look after a large unkempt yard and family, to attend church, county medical society, hospital staff and committee meetings.

The Journal of the Florida Medical Association aspires to offer its readers new ideas, new information and a different way of looking at things to aid the busy practitioner in providing more effective and efficient care for his patients. The editor is a readers' advocate but must also protect the rights of authors. The rights of those wishing to present new ideas must be equated with the rights of Journal readers whose desire not to spread themselves too thin must be stimulated to take time from their spare time to read the Journal. As all lives should harmoniously be balanced into three parts—work, rest and recreation, and if part of a physician's work is also recreation, then from time devoted to recreation he can subtract time for reading. To read is as important in the physician's life as clinical experience, and that is also to what the Journal aspires—to make your medical reading recreation.

Many things have impressed me about our president whose year of leadership nears completion. Following his nomination for president-elect by Will Sumner of Jacksonville, the seconding address by Henry Harrell from Ocala was a sincere recitation of Floyd's activities in behalf of organized medicine outside of Duval County, and I doubt that many in our society, other than his close friends, knew about these. Quiet and soft spoken yet when questioned on controversial issues, his replies reveal determination and strength of conviction founded on years of service to Florida medicine. Other impressive traits are the depth of his understanding and the display of his knowledge about problems facing the private practitioner as shown by his page in the Journal during these past twelve months. I am grateful to him for letting me perform a second year as editor. It's been fun.

Another person deserving recognition this past year is our managing editor, Louise Rader who, day after day, works to beat an always rapidly approaching deadline. Faced with a re-occurring monthly prospect of the next issue, she somehow finds time for writing letters, having manuscripts set in type then mailed to the author for approval,

pasting up a rough page copy which goes to the printer, then proofreading again all the copy he sends back, worrying about whether the printer will follow her instructions or get ads reversed, wondering if they will get the Journals to the Post Office when they said they would, typing and retyping again the editor's penciled-in changes on his manuscript, and then finding time to read through the journals of other states for suitable quotes to reprint and new ideas for us to try. She deserves a lot of credit.

Your Journal is sent to every hospital library in the state, to each state medical association, including Alaska, Hawaii and the District of Columbia, to medical schools in Denmark, Japan, Germany, Israel, Finland, England and New Zealand and to libraries in 17 foreign countries including Hungary and Russia. I think we all have a right to be proud of it.

It's been a great year, thanks to the many contributors and to the response of everyone requested to compose a special article, forward a news story, or a Dean's Page, supply information about Blue Shield or submit photographs for covers. Thanks for the encouragement and support. Thanks for reading us.

C.M.C.

Coronary Artery Vein Bypass Grafting

Coronary artery surgery has achieved an unprecedented popularity since the development of coronary artery vein bypass grafting by Favaloro[1] in 1967. Specifically, the bypass procedure involves the insertion of a reversed segment of autologous saphenous vein between the ascending aorta and a coronary artery distal to the point of significant obstruction. During the past year alone, approximately 20,000 patients in the United States have undergone coronary artery vein bypass graft surgery. Obviously, the surgery has been considered by many clinicians to represent a major breakthrough in the treatment of coronary arteriosclerosis, the leading cause of death in this country. In spite of this enthusiastic response, there is considerable controversy concerning the exact indications and contraindications for surgery.

Coronary artery vein bypass grafting appears to offer several advantages in the treatment of coronary artery disease. Clinical experience has shown that the procedure is applicable to a large percentage of patients with coronary arteriosclerosis. It does not disturb collateral circulation, and unlike the Vineberg internal mammary implant, it provides an immediate increase in coronary artery blood flow. Following surgery, symptomatic improvement occurs in 70-80% of the patients. Moreover, there is a high degree of correlation between symptomatic improvement and graft patency since most studies have reported that about 80% of the vein grafts are patent 1-2 years postoperatively. The national average for operative mortality following coronary artery vein bypass grafting is 10%;[2] however, operative mortality is reduced to less than 5% for patients without congestive heart failure.[3]

It is generally agreed that coronary arteriography and left ventriculography are required for the evaluation of all possible candidates for coronary artery surgery. From a technical viewpoint, successful surgery can be accomplished only when the arteriographic findings and left ventriculogram reveal a severe or total segmental coronary obstruction, a patent distal arterial vessel with good run-off, and radiographic evidence of viable muscle in the area to be perfused. The final decision for or against surgery is based on clinical evaluation of the patient.

According to the literature at this time, there is general agreement that patients with severe incapacitating angina pectoris without significant congestive heart failure and with anatomic lesions in the coronary arteries suitable for bypass graft-

ing should be offered surgery. The place of coronary artery vein bypass grafting for the treatment of patients with acute myocardial infarction and shock, patients with advanced chronic congestive heart failure from ischemic heart disease, patients with preinfarctional angina, and asymptomatic patients with coronary artery disease is still highly controversial. Studies at the Massachusetts General Hospital[4] indicate that a few patients with acute myocardial infarction and shock can be salvaged by intra-aortic balloon counterpulsion, early coronary arteriography, and emergency coronary artery vein bypass grafting; however, a certain number of the patients who survive surgery remain in chronic congestive heart failure and succumb during the late postoperative period. Spencer,[5] at the New York University Medical Center, has shown that the operative mortality following coronary artery vein bypass grafting in patients with advanced chronic congestive heart failure is 10-20%; moreover, the degree of improvement in surviving patients is often limited and may be negligible. Emergency coronary artery vein bypass grafting has been recommended for patients with preinfarctional angina in an effort to prevent death from subsequent myocardial infarction. Opponents to this approach have argued that most patients survive an acute episode of preinfarctional angina; however, because of the relatively high risk of death in the subsequent year, the patients should be considered for elective surgery, when the operative mortality is less, soon after the preinfarctional angina subsides. At the present time, coronary artery vein bypass grafting for asymptomatic patients with coronary artery disease does not seem justifiable since insufficient data has been accumulated to determine if surgery either reduces the incidence of subsequent myocardial infarction or prolongs life.

While coronary artery vein bypass grafting appears to offer considerable promise for the treatment of patients with coronary artery disease, it is apparent that there is a crucial need for additional studies to accurately assess the results of surgery. Only after the true results of surgery are determined will the medical profession be able to correctly judge the limits and place for coronary artery vein bypass grafting. Certainly, long-term follow-up studies should be conducted on all patients subjected to such surgery. Also, control studies comparing the results of medical and surgical treatment of patients with near comparable coronary artery disease would be extremely valuable. Follow-up studies should include data concerning survival, the clinical evaluation of the patient, repeat coronary arteriography and left ventriculography, and the results of physiological testing. Every effort should be made to obtain objective results since experience with sham procedures has proved that the presence or absence of angina, a completely subjective complaint, is an unreliable method for evaluating the results from surgery for coronary artery disease.

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Daniel B. Nunn, M.D., Jacksonville.

Each second we live is a new and unique moment of the universe, a moment that never was before and never will be again. And what do we teach our children in school? We teach them that two and two make four and that Paris is the capital of France. When will we also teach them what they are? We should say to each of them: Do you know what you are? You are a marvel. You are unique. In all of the world there is no other child exactly like you. In the millions of years that have passed, there has never been a child like you. And look at your body—what a wonder it is! Your legs, your arms, your cunning fingers, the way you move! You may become a Shakespeare, a Michelangelo, a Beethoven. You have the capacity for anything. Yes, you are a marvel. And when you grow up, can you then harm another who is, like you, a marvel? You must cherish one another. You must work—we must all work—to make this world worthy of its children.

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"Floyd K. Hurt speaks with a depth of knowledge and vision on the challenges facing organized medicine. His progressiveness, deliberateness, and thoroughness will be well placed if he receives the delegate call to election."

This succinct appraisal of Floyd Hurt was written two years ago as Florida's pioneer medical society proudly nominated one of its past presidents to the office of the President of the Florida Medical Association. His colleagues had an abiding faith in his ability and capabilities.

After all, here was a man who had met the test and proved his mettle to his county society and to his community. He was further prepared by having served as president of the Florida Radiological Society. Within the FMA he had been chairman of the Council on Medical Economics and of the committees on Member Insurance and on Florida Investment Trust. In addition to a very active practice in radiology he has found the time to serve on the Blue Shield Board and chair its Claims Committee for years.

Perhaps his greatest contribution to Florida medicine, however, was his seven years of dedicated service as Secretary-Treasurer of the Florida Medical Association. Small wonder, then, that the Duval County Medical Society knew it had a real champion when it nominated Floyd Hurt for the presidency of FMA in 1970. Here was a man of demonstrated reliability and devotion—a man seasoned by many years in policymaking positions within organized medicine. Indeed, here was a man the presidency needed.

At the closing of the tumultuous third session of the 1970 House of Delegates, Dr. Hurt was elected. His acceptance speech was brief and to the point. He said, "I appreciate this honor; and I do consider it an honor. A man was opposing me for whom I have a great deal of respect. Even though we have [had] differences of opinion at our House, let us not continue the debates we have had here today. Let's present a united front. United, we can solve our problems."

In the year that followed as president-elect, he devoted both his time and talents to unifying the organization and proceeding with the task ahead. As our president, Floyd has held a firm but gentle hand on the helm, maintaining both the control and respect of the membership through a very exciting year. He has overseen the activities of the executive staff and has been knowledgeable concerning more than 200 ongoing programs involving dozens of councils and committees and hundreds of physicians actively involved in formulating policies. He has been in attendance at the meetings of the AMA House of Delegates for many years, and is extremely well-informed concerning organized medicine at a national level. He has developed a keen insight into our State Legislature and is known and respected by our U.S. Congressional Delegation. His leadership and influence during the period of expanding growth of the Florida Medical Association has been an inspiration to those of us who have served with him.

When first meeting Floyd, one senses the characteristics of a calm, polite and gentle person. As one gets to know him better you can identify those additional traits that earned for him the confidence and faith of his peers; he possesses leadership, determination, responsibility, perception and stability, having the ability to identify the problem, reduce it to its simplest terms and work out a reasonable and equitable solution. Floyd is an extremely versatile person and his hobbies and interests include golf, art, physical fitness, his family, his home and travel.

The staff and membership of the FMA are indeed indebted to Floyd Hurt for his many years of service and wise counsel. Similarly, are we indebted to his lovely wife, Verona, who served through the understanding of and love for this fine man. Together they now step aside as our president and his lady, but if we know these two well they will always respond to the call for service by organized medicine.

James W. Walker, M.D.
Jacksonville

Continuing Medical Education

The FMA and You

William H. Hubbard, M.D.

Several years ago, while being cross-examined in a courtroom, I was suddenly startled by a realization often not considered. At this time I was an expert medical witness providing testimony of disabilities sustained by the plaintiff from the use of "defective" rental equipment. Moments previously the plaintiff's attorney asked questions pertaining to my qualifications. Now the defendant's lawyer was attempting to discredit these qualifications.

"Previously it was established that you were a member of the local county medical society and the Florida Medical Association. Kindly answer yes or no," queried the defense lawyer.

"Yes," I answered.

"Now, answer yes or no. Is it not true that if you are a graduate of an approved medical school, have a Florida medical license, and practice in the community that you are eligible to join these organizations by simply paying your dues?"

"Well, yes," I meekly retorted.

"That is, further to say, that no specialized medical training is required to be a member of these groups?"

"Yes," I retaliated mildly.

"Well, then is it not also true that you can remain a member of these organizations by simply paying your annual dues, unless you are subsequently convicted of a felony or an abortion?" asked the defense attorney. "Answer yes or no."

"Yes," I added.

"That's all, your Honor." The defense lawyer sat down.

Moments of contemplation came over me. Is this what membership in the county medical society and the Florida Medical Association really means? Simply paying your dues?

FMA Membership Meaning

What does FMA membership mean to you? If you are a member of the local county medical society, do you need the FMA? Are these groups just a means of collective bargaining? Perhaps these questions should be answered individually by the "silent" majority of members. Would the answers be approximately the same for the 7,000 plus members of FMA? This conclusion would certainly be doubtful. A trite expression would be applicable here. "You only get out of an organization what you contribute to this organization."

Nevertheless, let's review basic principles and philosophy, which at times are lost in the humdrum of daily living and work. Ideally, the state association is only as strong as its active components, namely, the county societies. Without functioning county societies, there would be no active Florida Medical Association. Thus, when speaking of the FMA, it is also understood that these units are included. Moreover, without the state associations, the operations of the American Medical Association would be greatly hampered. In effect, this discussion involves the whole network, county medical societies, Florida Medical Association and American Medical Association. Many laymen would shorten this network by stating, "organized medicine."

Idealistically speaking again, the FMA is an organization for the advancement of the profession in Florida—scientifically, socially and civically. The FMA strives for its members to attain and to sustain the highest possible medical and professional standards and ethics. The communities in Florida look to the FMA to maintain effective policing procedures, thus insuring that all its members are honest and honorable as well as skillful practitioners. Social advancement refers to the sociological aspects of Florida communities. FMA members should provide voluntarily specialized advice and leadership in promoting coordination of all health activities in the communities. In addition, intellectual isolation should not prevent their interest and participation in civic activities of the nonmedical communities as citizens.

Dr. Hubbard is director of medical education for Halifax District Hospital at Daytona Beach and chairman of the Florida Medical Association's Committee on Continuing Medical Education.

Since these ideas are broad in scope, one emphasis should be discussed—sustaining the highest possible medical and professional standards. Formerly standardized and regulated formal education in medical schools followed by state licensing examinations and board specialty requirements with testing procedures assured the public that physicians would use the best techniques and information available in rendering the highest quality of medical services. Now with medical science and technology doubling its volume of knowledge every five to seven years, it is easy to understand the necessity for physicians to participate in continuing medical educational programs. These efforts are methods for physicians to continue to maintain professional competency, with the medical advances being fully implemented into the day-to-day care of patients. Thus, would it not be correct to assume that the FMA is vitally interested in the continuing competence of Florida physicians? On the other hand does not membership in the FMA also imply that a physician is striving to sustain the best possible medical standards? To accomplish this goal, should not the FMA require some annual minimal continuing medical educational activities for the maintenance of membership status?

FMA Maintenance Membership Study Requirements

Many authorities have expressed the interest of state governments requiring relicensure of physicians by either certification of acceptable performance in continuing education programs or upon the basis of challenge by reexaminations. Specialty groups, such as the American Board of Family Practice, might establish mechanisms for periodic reexamination for continuance of certification in a particular specialty. Actually this responsibility of maintaining the physicians' competency should be accepted by the state medical associations. Several state associations, such as Oregon, have already accepted this challenging task. In Florida there is concern that the legislature may take this initiative, as was done for pharmacists. The pharmacists are required to show that 15 hours of continuing education have been obtained each year in order to renew their licenses. Furthermore, the types of continuing educational programs might be determined by the legislature or one of its agencies if these requirements were made mandatory by state law. Thus, if the FMA undertook this responsibility first, the practicing physicians may determine through their state association which or what educational courses would be relevant to their own practices.

Along these lines, do not let good intentions lead the FMA astray in formulating a highly complex and complicated system of insuring the highest quality of continuing medical educational programs. This type of endeavor might create a "Frankenstein monster" possessing a bureaucracy of preevaluation forms and record keeping with classification of various categories and subcategories. The accountability mechanisms may function as "bookkeeping nightmares" for administrative secretaries and clerks. These activities may develop into ones of filling in the right blanks without having any real educational experience. All efforts should strive for simplicity and effectiveness.

Moreover, there are multiple varieties of continuing educational needs and multiphasic techniques of learning for the Florida physicians. As Will Rogers once said: "We all are ignorant, but only on different subjects." This, the esoteric, theoretical and academic aspects are needed and desired by some physicians as well as the practical, common, therapeutic information for others. No one is the expert on all educational needs and desired learning techniques. Thus, the FMA should establish general principles and should not create a multitude of specific requirements with exceptional minutia.

In addition, the question of semantics "raises its old ugly head." The word "acceptable" should probably be used instead of "approved," in reference to the FMA's evaluation of continuing medical educational programs. Other activities of our state association involve the endorsement of medical affairs' activities by various organizations, institutions or groups. This endorsement consists of having "approval" by the FMA, which is also divided into three different types. If this term is also used for educational programs, it might imply the whole contents and all speakers have been thoroughly investigated with subsequential high recommendation and endorsement by the FMA. To perform this latter function for all the educational programs being offered in Florida would require two or three full-time doctors and five to ten administrative personnel. These "hang-ups" can be unshackled by using the word "acceptable" for the involved courses.

Finally, a workable system may be a minimal number of "acceptable" study hours each year,

with the realization that this method is not intended to cover the whole array of learning techniques and types of educational experiences. Specifically, reading journals and textbooks should be discussed. Many physicians utilize their specialty journals to keep them abreast of newer knowledge and skills. This method can be effective and simple for many busy practitioners. To evaluate and to grade this type of learning experience, however, is difficult. Nonetheless, this activity is taken for granted in considering the "minimal number of acceptable study hours" and is not required to be evaluated. That is, reading should not be utilized as the only way to maintain competency. A minimal of other activities should be implemented into the continual education process. Ideally, there should be the opportunity for the learner to express his thoughts in some type of feedback mechanism. Reading of journals might passively express new medical knowledge and techniques, but it alone does not effectively change the attitudes of the reader sufficiently to incorporate improved medical care into his daily practice. What, then, are some of these minimal activities which might be acceptable for the required study hours for the yearly renewal of FMA membership?

Acceptable Continuing Medical Education

The FMA should establish general principles and guidelines for its members to utilize in their endeavors for sustaining the best possible medical standards in the Florida communities. Before delineating these principles, a general theme should be emphasized. Each member should regularly schedule time for educational activities which should include partial integration into his daily medical practice, such as hospital medical staff or clinical departmental meetings and county medical society's programs. This latter concept is on local emphasis with involvement of a physician's own patient problems in an educational experience. Furthermore, each FMA member should structure his own continuing learning efforts according to his own particular needs. This theme of personalized structure according to needs and to learning abilities with some local involvement cannot be overly stressed.

In structuring one's efforts in these endeavors, the following principles should be used:

1. Utilize some method or mechanism to determine a deficiency or a need for improvement;
2. Select an educational program or course with predetermined objectives in solving the discovered need or deficiency;
3. At a later time, evaluate how effective this program or experience was in accomplishing these objectives or solving this deficiency.

Various methods can be employed to discover one's needs in medical education. Self-assessment tests or medical practice profile evaluations can be undertaken voluntarily. Moreover, local morbidity and mortality statistics or medical audit committee activities can help to pinpoint areas for improvement. Thus, it will not be necessary to pick a program because the subject sounds "catching" or interesting, or the location is ideal for a visit at that season of the year, or a particular speaker is entertaining. With deciding on a need for improvement in patient care management and with determining certain objectives to be accomplished, a doctor may be able to reasonably choose a program from the multitude of courses being offered. Furthermore, this physician will attend this program with certain areas to learn and with a definite purpose in mind. Incidentally, it should be mentioned that work and play should be separated. It is possible to mix effectively both of these activities if the frame of reference is properly employed. If you attend a medical program mainly to have an excuse for playing golf, swimming or fishing, then there will not be much effective learning. Finally, at a later time, the physician should reevaluate the discovered need and find out if there has been any improvement. Effective learning affords a change in attitude and behavior to assist in the improvement of daily medical care.

Suggestive Mechanics of Reporting Study Hours

The logistics and mechanics of reporting acceptable programs attended should be presented. These guidelines are only suggestive ones without any formal approval at this time. Certain categories of continuing medical education courses would be automatically acceptable without prior evaluation. These would be programs by approved American medical schools, hospitals with close association with medical schools, national and regional associations, and national voluntary health associations. Others would require completion of a medical educational evaluation from 30 days prior to the program's presentation. This form would be simple in nature

with blanks for general information, such as title of program, speakers, sponsoring group, dates, time, etc. The FMA Continuing Medical Education Committee would review these completed forms and determine if this program is acceptable or not acceptable. If the latter is decided, the sponsoring group would have the choice of repeal by referring the program to the FMA Board of Governors. Examples of these programs would be courses presented by hospitals without medical school affiliations, local county medical society and voluntary health association programs. Admittedly in starting a procedure for evaluating the multitude of continuing medical education courses, there will be misunderstandings and differences of opinion. These steps, however, would be in the right direction for accomplishing our goals of maintaining the physician's competency. Nonetheless, it should be mentioned that the FMA would confine these evaluation activities to courses presented in the state of Florida, without attempting to review overseas or "aboard ship" medical programs.

Secondly, the FMA should establish a central coordinating system for recording all postgraduate medical courses being offered in Florida. By purchasing an electrofile card machine, the FMA can carry out this function efficiently. The requirement for a minimal number of study hours for FMA membership maintenance would be the stimulus for all groups to report their educational programs to the FMA central office. In this fashion, the list of acceptable courses could be compiled for distribution. One method of distribution might be the incorporation of a center fold listing in the FMA Journal. All members, thus, would have access to possible courses which may fulfill their educational needs.

Summary

The meaning of FMA membership is discussed with emphasis on the scientific advancement of the medical profession within the Florida communities. In an attempt to sustain the highest medical standards of its members, the FMA should establish a yearly minimal number of study hours for maintenance of membership status. Simplicity and effectiveness should be the main guides in organizing a workable system to meet these goals. An underlying theme should be individualized educational needs and learning abilities coupled with some local patient-problem educational efforts. Certain principles regarding continuing medical education activities are delineated. Moreover, the FMA should assume a function of coordinating all postgraduate medical education programs being offered in Florida. Finally, suggestive mechanics are discussed for the reporting of these minimal study hours.

▶ Dr. Hubbard, Box 1990, Daytona Beach 32015.

Dr. Hurt Seeks Response to AMA Poll

FMA President Floyd K. Hurt, M.D., has urged all Florida AMA members to respond to a recently-mailed AMA membership opinion poll.

Questionnaires were mailed in March to 183,000 nonfederal AMA members, including several thousand in Florida in what AMA House Speaker Russell Roth, M.D., termed an "unprecedented opportunity" for members to express opinions as to policies and programs of the AMA.

Dr. Hurt noted that last year he wrote letters to all Florida AMA members who had not renewed their membership in an effort to determine the reasons for nonrenewal.

"A common complaint was that physicians at the grass roots have little or no voice in AMA policy matters," Dr. Hurt said. "The current poll gives all AMA members an opportunity to be heard, and I would hope that all our AMA members will take advantage of this by completing the questionnaire and returning it at the earliest possible date."

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Medical News

Take Issue with the AMA

At the March meeting of the FMA Board of Governors, Dr. Francis T. Holland stated that the delegation feels that we should emphasize that anyone who has a beef or gripe against the AMA has the opportunity to present this to his county medical society and to the state association; and we in turn, will take it to the AMA. Also, anyone not wishing to go through this procedure can attend the meeting of the Council on Long Range Planning in San Francisco in June or in Cincinnati in November and be heard. He further proposed a special open sitting of the FMA Delegation to the AMA at our annual meeting in Hollywood in May. Anyone with a gripe or suggestion will be heard.

Miami Pediatricians Meet

The 23rd Annual Seminar of the Greater Miami Pediatric Society will be held at 7:30 p.m., May 17-18, at the Mailman Center for Child Development in Miami.

Information may be obtained from John F. Gibby, M.D., President, Greater Miami Pediatric Society, 10260 S.W. 56th Street, Miami, Fla. 33165.

Family Medicine Program Upgraded

The Division of Family Medicine at the University of Miami School of Medicine has been upgraded to departmental status, according to Dean Papper, who announced the appointment of Lynn P. Carmichael, M.D., as acting Chairman.

Meeting of Legal Medicine College

The Annual Clinical-Professional Meeting of the American College of Legal Medicine, will be held May 12-13 at Miami Beach.

Lawrence V. Hastings, M.D., LL.B., of Miami, will participate in a panel on "New Concepts in Medical Malpractice," to be presented during the forenoon of May 12. Dr. Hastings, a Fellow of the College, will speak on "Modern Medical Malpractice Law: The Pendulum Swings."

Two physician-lawyers from Florida nominated for election as Fellows are Dewey H. Jones, III, M.D., LL.B., of Satellite Beach, and Walter C. Ward, M.D., J.D., of Miami.

Registration fees of $75 for members and $125 for nonmembers will be charged. Additional information about the meeting may be obtained by writing to the College at 1340 North Astor Street, Suite 1201, Chicago, Illinois 60610.

New Ob.-Gyn. Chair at Florida

An anonymous donor has given $700,000 to the University of Florida Foundation to endow a second chair of obstetrics and gynecology in the College of Medicine.

Harry Prystowsky, M.D., Professor and Chairman of the Department of Obstetrics and Gynecology, said the gift would underwrite the salary of a faculty member appointed to the chair and his program. This development also will strengthen and permit expansion of well established programs in reproductive medicine and biology, he added.

New ACP Members

Florida physicians recently admitted to membership in the American College of Physicians are: Victor I. Hochberg, M.D., Jack B. Miller, M.D., and Barry F. Portnoy, M.D., all of Hollywood; Rafael A. Penalver, M.D., and Eugene R. Schiff, M.D., both of Miami; Federico R. Justiniani, M.D., of Miami Beach; and Rob R. Bunch, M.D., of St. Petersburg.

"The history of science, and in particular the history of medicine . . . is . . . the history of man's reactions to the truth, the history of the gradual revelation of truth, the history of the gradual liberation of our minds from darkness and prejudice."

– George Sarton, from "The History of Medicine Versus the History of Art"

Should nongovernment scientists and physicians play a role in drug regulation?

Opinion

Results of a questionnaire to 7000 physicians:

82.8%
Physicians should play a role

78.3%
Independent scientists should play a role

69.8%
Medical academicians should play a role

Opinion & Dialogue

Dialog

Should nongovernment scientists and physicians play a role in drug regulation?

Doctor of Medicine

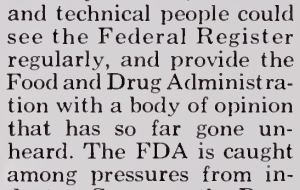
Herbert L. Ley, Jr., M.D., M.P.H., Formerly Commissioner, F.D.A. (1968-1969) Currently Medical Consultant

In order for drug regulation to be effective, participation in the regulatory process from nongovernment physicians and scientists must be encouraged. Without such involvement, there will continue to be a high degree of controversy surrounding any regulations promulgated by the Food and Drug Administration.

There are two areas in which participation and communication by nongovernment physicians and scientists could significantly improve the process of regulation. First, scientists and physicians throughout the country could become involved in consulting relationships with the Food and Drug Administration in important scientific areas while regulatory policies are being evolved. If nongovernment professionals could bring their expertise and experience to bear early in the decision-making process, they would have less reason to criticize the final outcome.

Secondly, practicing physicians, academic physicians, and academic-based scientists could make it their business to comment on proposed regulations appearing in the Federal Register. Ideally, a system could be instituted whereby medical, scientific and technical people could see the Federal Register regularly, and provide the Food and Drug Administration with a body of opinion that has so far gone unheard. The FDA is caught among pressures from industry, Congress, the Presidential Administration and consumers. It should also feel pressures from practicing physicians and scientists.

In order to become more involved in these stages of the drug regulatory process, nongovernment physicians and scientists should begin to exercise their influence through their respective professional organizations,



state and national medical societies, and specialty groups. Logically, a letter from these organizations representing a collective opinion has far greater weight in the regulatory process than individual letters. If the Food and Drug Administration receives opinions from these organizations early, before a regulation gets into the Federal Register, they are in a good position to respond with further study and review. Without such dissenting opinions, there is very little incentive to make changes in proposed regulations.

One instance in which practitioners did influence drug regulatory affairs in this way is the recent controversy that arose over the legitimacy of drug combinations. The strong opinion of practitioners on the value of such medication in clinical practice played a very prominent role in making the Food and Drug Administration modify its rather restrictive policy.

Another way in which practitioners can effectively influence drug regulations is by working with drug manufacturers conducting clinical trials of chemotherapeutic agents. When a drug is rated other than effective it may only mean that there is a lack of controlled clinical evidence as to efficacy. Thus, physicians might offer to conduct clinical studies that could help keep a truly effective drug in the marketplace. The treatment of diseases such as diabetes and angina are areas where the practitioner can aid in clinical studies because patients suffering from these diseases are rarely found in the conventional hospital setting.

By working with ethically and scientifically sound study designs in his everyday practice, the practitioner could begin to play an important part in determining official ratings on drug efficacy.

Nongovernment physicians and scientists and the FDA should also improve their lines of communication to the public. The medical community must develop a voice every bit as loud as that of the consumerists, the press, and others who sometimes criticize without complete information. If not, much of w the medical commun *and* federal regulators will often be represente simplistic and somew misleading terms.

One illustration of misuse of the media in t regard is the recall of a coagulant drugs seve years ago. This FDA act was given publicity by press and television t went far beyond its pr able importance. The res was a very uncomforta situation for the prac tioner who had patie taking these medicatic Since the practitioner a pharmacist had not b informed of the action the time it was publiciz in most states they w deluged with calls fr worried patients.

The practitioner can tempt to solve these pr lems of inadequate comm nication in several wa One would be the creat of a communications l in state pharmacy societi When drug regulation ne is to be announced, the ciety could immediat distribute a message to ery pharmacist in the sta The pharmacist, in tu could notify the physicia in his local community that he and the physici could be prepared to a swer inquiries from p tients. Another approa would be to use profe sional publications t practitioner receives.

All of this leads back my opening contention: drug regulation is to be effective, timely, and relat to the realities of clinic practice, a better method communication and fee back must be developed b tween the nongovernme tal medical and scienti communities and the reg latory agency.

ue

Maker of Medicine

Henry W. Gadsden,
irman & Chief Executive
fficer, Merck & Co., Inc.



n my opinion, it is the
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physicians.

here are several current
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n order to minimize this
l of arbitrary federal
ion, a way must be
d to give practitioners
voice and represen-
tation in government affairs. Government must be caused to recognize the essentiality of seeking their views. One of the difficulties today, however, is that there is no way for concerned practitioners to participate in the early stages of decision-making processes. They usually don't hear about regulations until a proposal appears in the Federal Register, if then. By that time a lot of concrete has been poured, and a lot of boots are in the concrete.

Physicians in private practice, and particularly clinicians, should press for representation on the advisory committees of the Food and Drug Administration, joining with academic and teaching hospital physicians and scientists who are already serving. Though practitioners may not have access to all available information, the value of their clinical experience should be recognized. Clinicians, for example, rightly remind us that difficulty in *proving* precise effects does not necessarily mean a drug is ineffective.

Unless practitioners are more involved in drug regulations, it will be increasingly difficult for the pharmaceutical industry and scientists elsewhere to make optimal progress in drug development. The benefit/risk ratio must be re-emphasized, and as part of this it must be acknowledged that benefit can come from the judgments of medical science as a whole. Even this concept, unfortunately, is not always accepted in drug regulatory processes. For example, if current medical opinion holds that an excess of total lipids and cholesterol in the blood is probably predisposing to atherosclerosis, and if a drug is discovered which reduces total lipids and cholesterol, the drug ought to be accepted *prima facie* as a contribution to medical science . . . until someone disproves the theory. The sponsor should not have to prove the theory as well as to develop and test the drug.

I feel a major new effort must also be made to erase the feeling of mistrust of medicine and of medicines that seems to be growing in the public consciousness. Triggered primarily by strident announcements in Washington, people are reading and hearing confidence-shaking things almost continuously. Although challenge and awareness are essential to medical advancement, our long-term goal is constructively to build, not destroy. This means strengthening patient-physician relationships based on mutual confidence and trust. And in matters of health policy, it means working toward participatory rather than adversary proceedings—where everyone with an interest and a capacity to contribute has an opportunity to be heard . . . and, if that opportunity is not spontaneously afforded him, he may seek it.

Opinion & Dialogue

What is your opinion, doctor?
We would welcome your comments.

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Who Owns Blue Shield?

Robert E. Zellner, M.D.

"Who owns Blue Shield of Florida?"

This is a question a newspaper reporter asked me a few months ago, and I will admit that I was stumped for the moment. Who does own Blue Shield? I'd never given it much thought.

"Does the Florida Medical Association?", she asked.

No, Blue Shield was *organized* by the Florida Medical Association, but it did so very carefully in a manner in which it would not be liable for Blue Shield debts, its suits, its losses or its failures.

"Do the doctors of Florida own it?"

No. When it was founded some 28 years ago, many doctors of Florida lent Blue Shield money in order that it would have the necessary reserve funds to begin operations, but these were loans, not stock purchases, and the money was all repaid shortly after Blue Shield began operations.

"Do the contract holders?"

No. Blue Shield is not a mutual company and the contract holders have no direct voice in its management, although they are the primary beneficiaries of its services.

"Does the House of Delegates?"

No. The House of Delegates elects one-third of the Blue Shield Board of Directors each year and it often issues directives to the Board, but it actually does not own Blue Shield, nor does it exercise ownership control.

"Well, then, who does own Blue Shield?"

After giving it considerable thought and after re-reading Blue Shield's charter, I found something that should have been self-evident from the beginning. Blue Shield was established under a special law enacted by the Florida Legislature in 1944, permitting the creation of a nonprofit corporation for the purpose of providing medical payments insurance, to be governed by a Board of Directors who have no financial interest in the corporation but *who exercise ownership control and who are legally liable for its activities and for its fiscal soundness.* In brief, the Blue Shield Board assumes all the responsibility of directing a multimillion dollar corporation but without the remuneration usually associated with such responsibilities. If Blue Shield is sued, it isn't the FMA, it isn't the House of Delegates, it isn't the doctors of Florida; it is the members of the Blue Shield Board of Directors, collectively and individually, who are liable before the law for any action which Blue Shield may have taken or not taken.

Once one recognizes these facts, it explains several things: (1) Why didn't the Florida Medical Association retain control of Blue Shield when it was first organized? As already mentioned, Blue Shield was by no means a sure thing at its inception and the FMA leaders at that time very wisely, in my opinion, decided not to subject the Florida Medical Association assets to double jeopardy by assuming Blue Shield liabilities. It was decided further that a Board of Directors composed of physicians and laymen elected by and responsible to, but because of the nature of corporate law independent of, the physicians of Florida would best serve the purpose for which the new organization was being founded. The growth of Blue Shield in Florida and the harmonious relationship which has largely prevailed between Blue Shield and the medical profession have borne witness to the good judgment in this regard of the founders of Blue Shield in Florida.

(2) Why does Blue Shield frequently disregard the directives of the House of Delegates?

Dr. Zellner, of Orlando, is Chairman of the Board, Blue Shield of Florida, Inc.

It doesn't. In my experience, Blue Shield has *never* disregarded a directive of the House of Delegates. Sometimes such directives are poorly researched and are passed because of the persuasiveness of one or two individuals. Sometimes they are impossible to implement immediately and, occasionally, never. I was personally responsible for one such incident. As a member of the House of Delegates, I introduced a resolution directing Blue Shield immediately to stop selling "J" contracts, its original contract. This passed the House. Two years later when I was elected to the Blue Shield Board, I was outraged to find that Blue Shield was still selling "J" contracts. I then learned that if Blue Shield had immediately stopped selling "J" contracts, it would literally have gone out of business! This contract constituted practically all of its business. Blue Shield cannot fail to renew a contract as long as a policy holder continues to pay the premium. To replace a contract, it is necessary to draw up a new contract, have it approved by the State Insurance Commissioner, offer it to the contract holder, and get his consent to make the change. All this takes time. Although Blue Shield no longer sells new "J" contracts, it still has about 150 in service, some of them held by doctors who refuse to give them up. As a somewhat chagrined member of the Blue Shield Board, I realized why the Board in its wisdom had not implemented the resolution that I had sponsored.

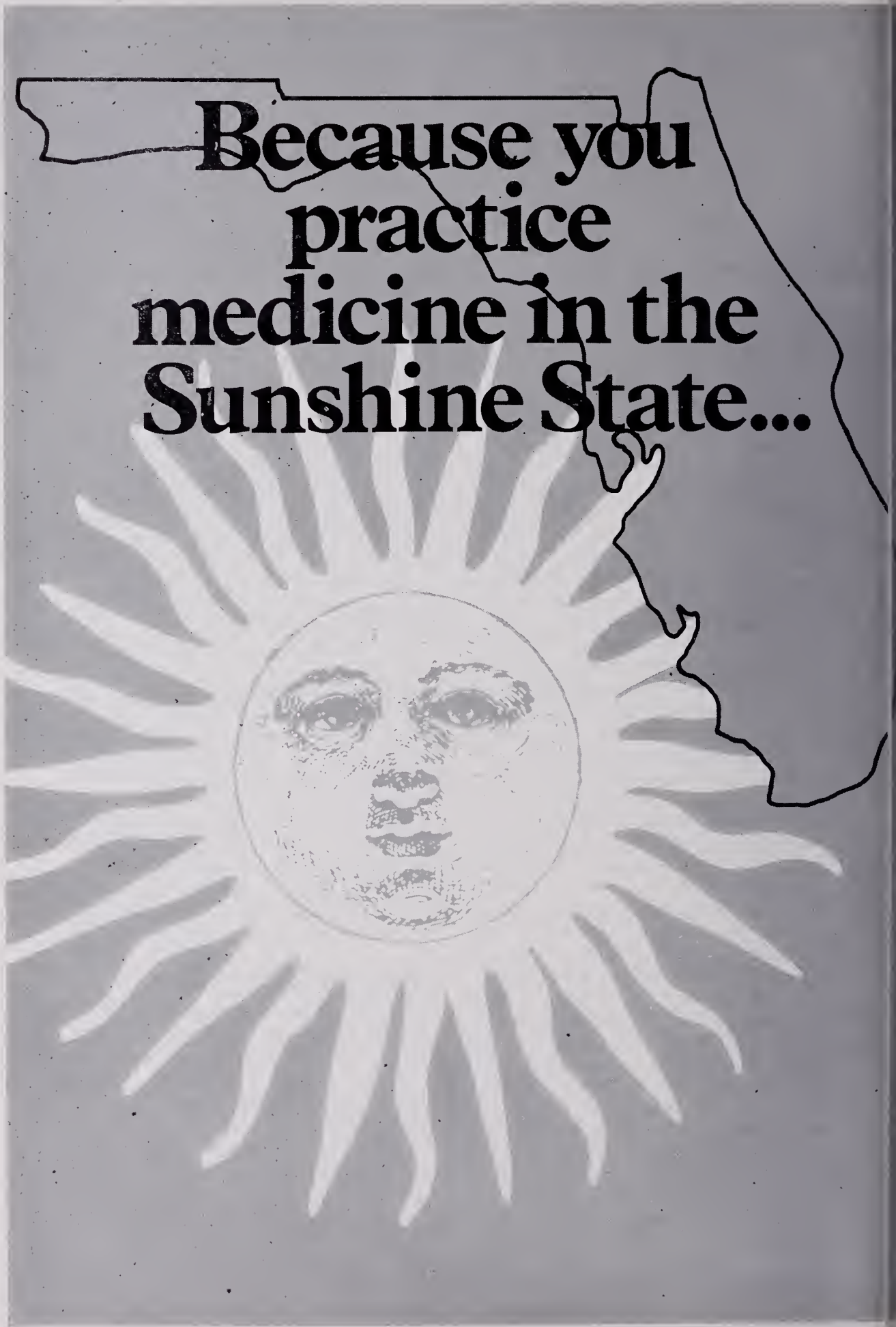
There are other instances where the Blue Shield Board, fully cognizant of its responsibilities to its colleagues individually and to the medical profession generally, has not been able to implement directives from the House of Delegates. My experience has been that the Board feels a heavy responsibility to follow such directives as much as possible and where this is impossible, to explain to the best of their ability the reasons why this could not be done. The Board has sole responsibility before the law for its actions; therefore, it must exercise final judgment on everything it does. It all boils down to a matter of confidence in the Board's judgment and its integrity. It seems rather odd that men who have been entrusted with high office in the Florida Medical Association, such as its President, Secretary-Treasurer, Speaker of the House, AMA Delegate and so forth, would become suspect as Blue Shield Board members. Such occasionally seems to be the case. The House of Delegates has the opportunity of replacing one-third of the membership of the Board annually. Where there is a serious breach of confidence, it would seem advisable that the House exercise this option.

(3) "Why does anyone serve on the Blue Shield Board of Directors?" That's a very good question, one which I frequently ask myself. I won't attempt to answer it for the lay members, except to say that without exception they are among the busiest and most highly regarded business and professional men in Florida, and their time is in constant demand. I am sure that they feel that they are rendering a very important public service through their Blue Shield activities. I can assure you that Blue Shield could hardly operate without the wisdom and advice of these gentlemen. As for physician members, I suppose that each of us might answer this question somewhat differently, but I rather think that we have a common feeling that we are fulfilling an obligation entrusted to us by our fellow physicians to bring to the public the opportunity to buy the best medical care coverage that a given amount of money can buy. This is a public service first assumed by the medical profession some 34 years ago, in Florida now 26 years ago, and, in my opinion, that it has done so in such a superb fashion it is one of the greatest accomplishments of medicine.

"Who owns Blue Shield?" Nobody, really. It is a nonprofit organization regulated by a Florida statute, sponsored by the medical profession, and operated in the public interest by 13 physicians and eight laymen elected by representatives of the doctors of Florida. No other group is more involved in doing the work of the medical profession. For this reason it deserves your patient understanding and support.

▶ Dr. Zellner, 515 North Orange Avenue, Orlando 32801.

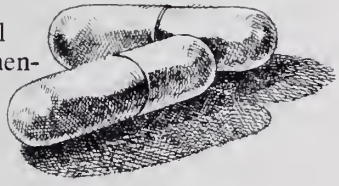
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Commentary

Editor's Note: This is in rebuttal to Dr. Franklin J. Evans' commentary, "Is This Legislation Really Necessary?" published on page 51 of the March issue of the Journal.

Death With Dignity: A Recommendation for Statutory Change

Walter W. Sackett Jr., M.D.

Such is the title of an article written in the *Florida Law Review* by its Editor-in-Chief, an official publication of the University of Florida College of Law. Yet, in a rather pointed article in the March issue of the *Journal of the Florida Medical Association,* Franklin Evans, M.D., L.L.B., has analyzed the need for "death with dignity" legislation with acrid thoroughness, much of which would single me out as the main culprit in such alleged silly legislation.

Would he then also indict Governor McCall of Oregon, who has been cited in the national press as having urged his legislature to initiate discussions in this very same area; would he also question the integrity of three other state legislatures, Hawaii, Montana and Utah, for having such legislation presently under consideration, or the other seven state legislators and one Congressman who have written me expressing interest in the subject, several with the avowed purpose of introducing similar legislation?

Strangely, the 'ballyhoo' with which Dr. Evans surrounds me and my Death with Dignity legislation has been meted out by respected branches of the media. CBS is currently editing an 18-minute showing for early release on the Mike Wallace program. This excerpt is being taken from a 30-minute film shown in England by ITV (a British TV network comparable to our NBC and CBS counterparts). ITV dispatched two program men and ten technicians from London to Miami to do the film, all of them following me to Orlando for a five-minute presentation before the Florida Conference on Aging. WTVJ (Miami CBS station) has done two 30-minute documentaries on the subject. A 1971 article in the *Southern Medical Journal* brought inquiries from numerous foreign nations, some of them from behind the Iron Curtain. Would Dr. Evans accuse me of engineering this 'ballyhoo'? If so, it certainly comprises expensive "ballyhoo," involving extensive research and documentation, including the countless hours, long phone calls to Miami and all parts of the country. Strangely, such 'ballyhoo' makes excellent exhibits in committee legislative deliberations and all legislators prize their file collections on their pet subjects.

In the prestigious *Florida Law Review,* Henry Brill expended some eleven pages in exploring various aspects of the situation, annotating 114 references, indicating a vast amount of research on the subject. I would recommend a perusal of this article to Dr. Evans.

At the President's White House Conference on Aging last December, two of the twenty-odd conference sections, in their final recommendations, expressed concern over the matter of death and called for governmental consideration of the problem. I personally had the opportunity of making a five-minute presentation on the Open Forum before some 4,500 delegates and was immediately besieged by some twenty reporters who quizzed me extensively. This resulted in a variety of news and radio releases by the syndicated media agencies, as well as several philosophical ones written under bylines of recognized reporters.

The experienced lay director of the hospital where both Dr. Evans and I work, in expressing admiration for and a need for such legislation, stated, "Don't kid yourself, some of our staff members will keep them alive until the last gong is rung." This statement came after I had remonstrated that in our hospital there was no need for such legislation. It was then that I recalled such incidents as when an 85-year-old man received sixty-odd transfusions (three a day) in the course of which process Code Four (Extreme Emergency Call) was called about six times. Nurses and aides, far closer to the patient than the physician

Dr. Sackett is a member of the Florida House of Representatives.

in those final hours, have uniformly approved the proposed statute.

In the thousands of letters in my files, I find the predominance of them from old folks who are unanimously in favor of such a law. Many of these had witnessed the agony of a loved one, a former shuffleboard or card-playing mate and contemplated with abject fear the indignity of a useless but scientifically-prolonged life. While Dr. Evans writes rather disparagingly of these emotional and sentimental communications, I can show him many which would put to shame the argumentative qualities of these articles written by either of us. Contrary to this, the few letters expressing opposition are of the crackpot variety and unsigned.

Laws lay down direction for the process of living. If there is no need for legislation, why would a doctor, patient and family look to a judge for direction in the case of a patient hopelessly ill with aplastic anemia and recurring, endless but unavailing blood transfusions? While this judge approved this desire for Death With Dignity and the patient was permitted to die, another circuit judge in our same Dade County previously had denied the request of a patient for death and ordered her leg amputated. While it looks like people in general, excluding Dr. Evans, see the need for such legislation it appears to me that even the courts have some need for it.

Incidentally, Dr. Evans writes of the lack of wisdom expressed in the provision that, in the case of an individual with no known relatives, a circuit judge would make the final decision after a unanimous recommendation by three physicians. Dr. Evans, in this assertion, demonstrates a glowing lack of knowledge of the proposed statute —there is no mention of a circuit judge in the present proposal.

Speaking of those 1,500 severely retarded individuals (*40% of whom are adults*), I recall the admission of a responsible physician involved in their care and a member of the Florida Medical Association, to the effect that 90% of them should be allowed to die. Upon my query as to why he didn't allow this to happen, he replied, "Are you nuts?" He then proceeded to inform me of the legal possibilities involved and his desire to avoid them until he had legislative intent for guidance. Taking the estimates of a nationally recognized authority in this field, based on the fact that the lives of these individuals can be extended to between 50-60 years, it will take 5 to 6 billion dollars of Florida taxes to produce artificially prolonged lives for these 1,500 individuals, 90% of whom are incapable of any rehabilitation; yet, in many areas of rehabilitation—jails, youth services and psychiatric institutions—we skimp along on budgets permitting simple care and very limited rehabilitative measures.

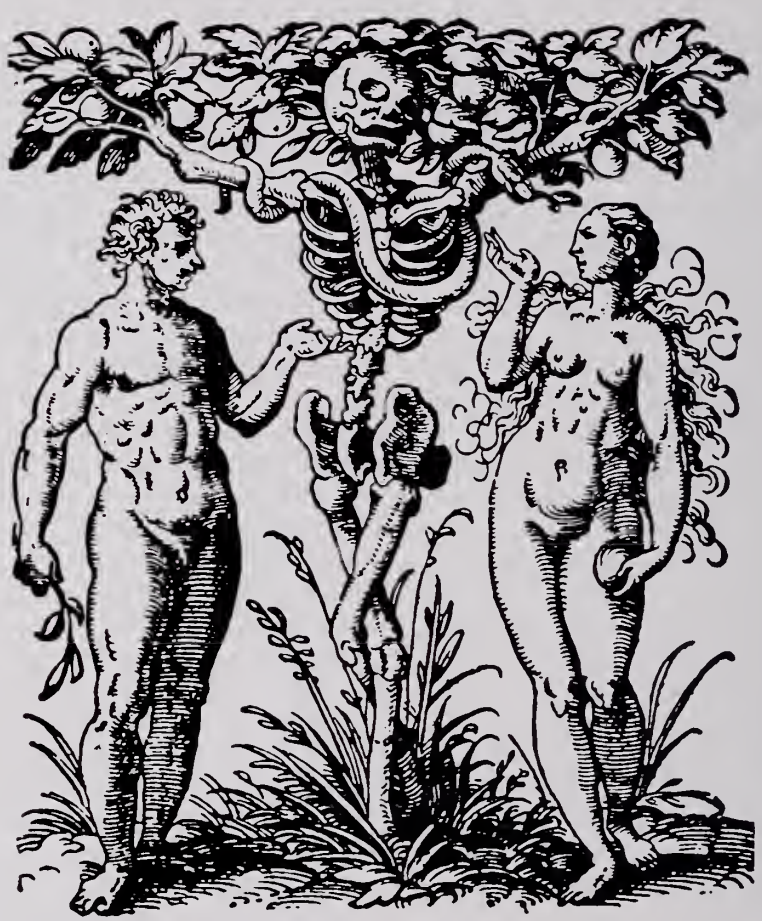
Turning briefly to the humaneness of this legislation, there are those who would accuse me of acting like God, particularly those writing in the Catholic press. This they do with complete disregard of the expressed statement of policy by Pope Pius XII, who in an encyclical of 1957, stated emphatically that there is no obligation for those caring for hopelessly ill patients to resort to heroic measures. The Pope further elaborated to the effect that drugs used with intent of affording comfort could be used even in the knowledge that they would hasten the end. In truth, in the needless prolongation of the life of a hopelessly ill person, then only would I feel that I would be acting like God.

Actually, Dr. Evans and I have, for over twenty years, been good friends, both medically and socially, but to resort to an old adage—in my efforts to promote this legislation, of Death With Dignity, "who needs friends like this?"

Dr. Sackett, 2500 Coral Way, Miami 33145.

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e: Antibiotics used in high doses for short periods of time to treat gonorrhea may mask or delay the ıptoms of incubating syphilis. Since the treatment of syphilis demands prolonged therapy with any ctive antibiotic, and since Trobicin is not indicated in the treatment of syphilis, patients being treated for ıorrhea should be closely observed clinically. Monthly serological follow-up for at least 3 months should nstituted if the diagnosis of syphilis is suspected. Trobicin is contraindicated in patients previously found ersensitive to it.

ı compiled from reports of 14 investigators. **Diagnosis was confirmed by cultural identification of *N. gonorrhoeae* on Thayer-tin media in all patients. Criteria for cure: negative culture after at least 2 days post-treatment in males and at least 7 days post-tment in females. Any positive culture obtained post-treatment was considered evidence of treatment failure even though the w-up period might have been less than the periods cited above under "criteria for cure" except when the investigator determined reinfection through additional sexual contacts was likely. Such cases were judged to be reinfections rather than relapses or res. These cases were regarded as non-evaluatable and were not included. JA72 1848-6

in; hematocrit and creatinine clearance; elevation of alka-ohosphatase, BUN and SGPT. In single and multiple-dose es in normal volunteers, a reduction in urine output was d. Extensive renal function studies demonstrated no con-nt changes indicative of renal toxicity.

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PART-TIME ADMINISTRATIVE MANAGER for Halfway House. Bookkeeping and typing required. Mental health experience preferred. Good salary. Mail resume to P.O. Box 5171, Gulfport, Florida 33737.

situations wanted

YOUNG ANESTHESIOLOGIST: Fully university trained—wide experience. Board certified, military complete, Florida license, wants busy location. Write C-536, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST: Board eligible, Age 31. Subspecialty endocrinology plus one year cardiology fellowship. Former chief resident, university trained, completed military obligations, Florida licensed. Would like to join group practice or partnership in internal medicine. Would prefer teaching appointment at community hospital combined with private practice available. Write C-532, P.O. Box 2411, Jacksonville, Florida 32203.

ALLERGIST, 42, certified pediatric allergy. Academic position university-affiliated hospital, head chest & allergy sections. Experienced chest disease, pulmonary function, tuberculosis, respiratory care, etc. Desires association with established practice, group, or consider progressive hospital lab. Prefer coastal areas. Inquiries: John McCloskey, M.D., 2380 Packard Ave., Huntingdon Valley, Pa. 19006.

RADIOLOGIST: Board certified, Florida license. Desires association with group, office, or hospital affiliations. Write C-543, P.O. Box 2411, Jacksonville, Florida 32203.

POSITION WANTED: Internist, board eligible, age 34, military obligation completed, Florida license and three years of excellent training desires partnership or group practice starting July 1972. Write C-548, P.O. Box 2411, Jacksonville, Florida 32203.

PSYCHIATRIST: Board eligible, Florida licensed, mature, prefer southern coastal area though will consider all opportunities. Available July 1972. Write C-545, P.O. Box 2411, Jacksonville, Florida 32203.

GYNECOLOGIST AND PSYCHIATRIST COMBINED: Board certified and board eligible, Florida license, prefer coastal area, would like opportunity to utilize both fields. Available mid June 1972. Write C-546, P.O. Box 2411, Jacksonville, Florida 32203.

PATHOLOGIST: Strong background large hospital laboratory direction, academic appointment, past president state pathology society among others, seeking challenge similar category or related administrative fields. Local references. Write C-531, P.O. Box 2411, Jacksonville, Florida 32203.

POSITION WANTED: 34-year-old board certified internist with two additional years cardiology catheterization fellowship, seeking position as Director of Cardiac Catheterization Laboratory. Prior administrative and teaching experience, military obligation complete, Florida licensed. Write C-547, P.O. Box 2411, Jacksonville, Florida 32203.

practices available

GERIATRIC PRACTICE AVAILABLE: For retired physician with Florida license. Contact Mr. Kwart, Medical Business Consultants, 9999 N.E. 2nd Avenue, Miami Shores, Florida 33138.

real estate

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BEAUTIFUL NEW SHOPPING CENTER now offering outstanding medical/dental office space. Your personal preference for interior design set-up available, occupancy mid 1972. Location in Confederate Point, Jacksonville, Florida. Call 771-7317 or write 4313 Savannah Ave., Jacksonville, Florida 32210.

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PRIVATE SUITES FOR IMMEDIATE OCCUPANCY: South Miami Medical Arts Building. Walking distance to Larkin and South Miami hospitals. Call 665-7523 or 667-3694.

FOR SALE: 2,700 acres, $625. acre, 29% cash, Volusia County between Daytona and Disney World. Other tracts available. Excellent group investments. Invest now in the "golden triangle." Contact A. E. Cleveland, Realtor, 2026 S. Atlantic Avenue, Daytona Beach, Florida 32018.

HOLLYWOOD—SPACE AVAILABLE. New Medical Offices. Will partition. Ideal location—Hollywood Boulevard. Riverside Military Academy Circle. For information call: Dr. Alvin Fisher, 3816 Hollywood Blvd., Hollywood, Florida. Phone (305) 989-9800.

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PROFESSIONAL BUILDING. Temple Terrace, Florida. Near Tampa and University of South Florida Medical Center. Space available September 1, 1972. Raymond J. Sever, M.D., P.A., 3000 Medical Park Drive, Tampa, Florida 33612. Ph. (813) 971-3250.

OWN YOUR OWN OFFICE IN CONDOMINIUM PROFESSIONAL BUILDING in downtown Winter Park. Contact Stanley Duane, 200 East New England Ave., Winter Park, Florida. Phone (305) 644-4808.

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Next Annual Meeting: May 3-7, 1972, Hollywood

VOL. 59, NO. 6

JFMA

MDS

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

JUNE 1972





Everybody experiences psychic tension.



Most people can handle this tension.



Some people develop excessive psychic tension and need your counseling,



and a few may need counseling
and the psychotropic action of Valium® (diazepam).

Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.

Valium®
(diazepam)

To help you manage excessive psychic tension

JFMA

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JUNE, 1972 • VOLUME 59 • NUMBER 6

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JUNE COVER—William J. Dean, M.D., 96th FMA President, in front of Florida Medical Association Headquarters Building, Jacksonville.

President's Page



Organized Medicine

Assuming the Presidency of the Florida Medical Association is a big job, and I assure you I will do all in my power to keep our organization strong during these rapidly changing times. By the time this appears in print, we will have completed what I know will have been a successful annual meeting at the Diplomat Hotel in Hollywood.

The art of medicine has become a more and more exacting science today, which behooves us to try to stay abreast of the advancements and changes in each of our fields. The practice of medicine has become a very frustrating experience. Just trying to remain independent in a free enterprise system with third parties seeming to engulf us steadily from all directions has become a chore. It is here that organized medicine must remain strong. If we can pull together for the common good of all concerned, I sincerely believe that we can be a real power in molding the future of medical care delivery in our country.

In the coming year we will face many problems which will not be easily solved. Some of these are already apparent—Guilds, HMO's, National Health Insurance, Peer Review, Foundations for Medical Care, Continuing Postgraduate Education with recertification, and many others.

I hope to use this page in the *JFMA* each month to discuss with you current problems that we will be facing. I sincerely solicit your support for "Florida Medicine" during this challenging year, and will appreciate your comments and advice as we move along together.

William J. Dean, M.D.

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Ger-O-Foam reduces pain[1] when its surface analgesic-anesthetic foam is massaged into the skin. This relief from pain facilitates increased range of motion in joints affected by rheumatoid or osteoarthritis, making prescribed exercise easier to perform. With Ger-O-Foam, pain relief occurs in minutes . . . lasts for hours.

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AVAILABLE: 1½ and 4 oz. cans. Approximately 125 applications in each 4 oz. can.

1. Gordon, E. E. and Haas, A., Indust. Med. & Surg. 28:217, May, 1959.



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- ☐ **belladonna alkaloids—for the hyperactive bowel**
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Composition: Each chewable, fruit-flavored, scored tablet contains: 16 mg. phenobarbital (warning: may be habit-forming); 0.1 mg. hyoscyamine sulfate; 0.02 mg. atropine sulfate; 0.007 mg. scopolamine hydrobromide; 40 mg. simethicone.
Contraindications: Hypersensitivity to barbiturates or belladonna alkaloids, glaucoma, advanced renal or hepatic disease.
Precautions: Administer with caution to patients with incipient glaucoma, bladder neck obstruction or urinary bladder atony. Prolonged use of barbiturates may be habit-forming.
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(from the Greek **kinetikos,**
to move,
and the Latin **sedatus,**
to calm)

KINESED®

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throat membrane with air until it is
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DBI® phenformin HCl tablets of 25 mg.
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Indications: Stable adult diabetes mellitus; sulfonylurea failures, primary and secondary; adjunct to insulin therapy of unstable diabetes mellitus.
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Warnings: Use during pregnancy is to be avoided.
Precautions: 1. *Starvation Ketosis:* This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria which, in spite of relatively normal blood and urine sugar, may result from excessive phenformin therapy, excessive insulin reduction, or insufficient carbohydrate intake. Adjust insulin dosage, lower phenformin dosage, or supply carbohydrates to alleviate this state. **Do not give insulin without first checking blood and urine sugar.**
2. *Lactic Acidosis:* This drug is not recommended

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Let's say you've decided that diet alone won't work in your adult-onset, nonketotic diabetic.

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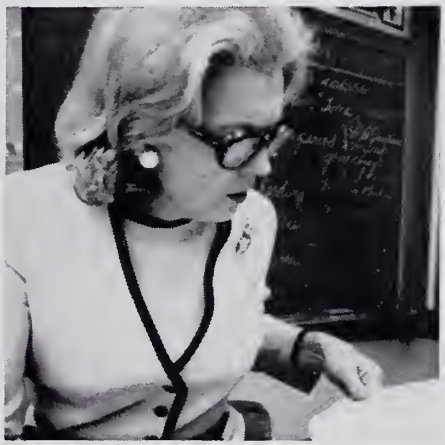
- Sulfonylureas promote release of insulin.
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- Overweight patients frequently have normal or high levels of endogenous insulin.
- DBI-TD lowers blood sugar without stimulating insulin secretion from the pancreas.

Usual dosage: one 50-mg. capsule with breakfast may be effective, or a second capsule may be given with the evening meal.

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phenformin HCl

Literary Hemorrhoids

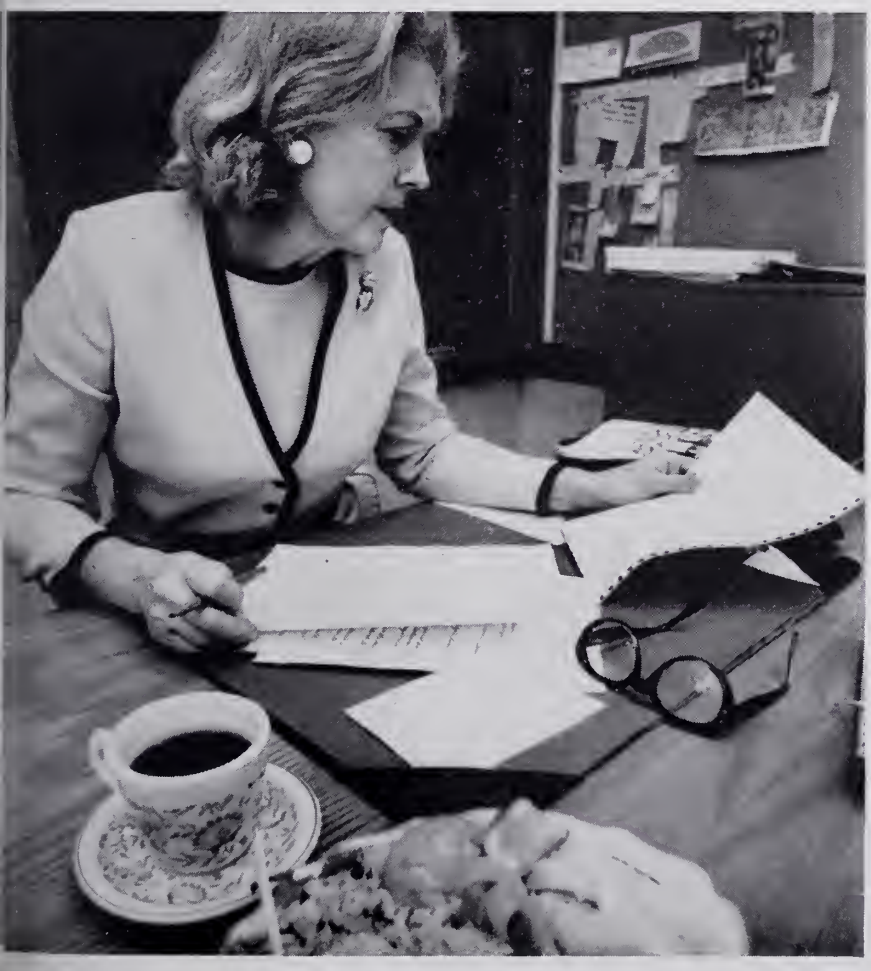
Mrs. S.R., 47, high school English teacher. A history of anorectal pain and burning of several years' duration. On and off weight reducing diets, the insufficient bulk of which has aggravated a chronic constipation problem. Subsequent straining at stool has precipitated an acute episode of internal-external hemorrhoids.



a typical proctological patient

to help relieve the pain, itching, burning associated with this and similar anorectal conditions

prescribe



Anusol-HC® hemorrhoidal suppositories with hydrocortisone acetate

Each suppository contains hydrocortisone acetate 10 mg, bismuth subgallate 2.25%, bismuth resorcin compound 1.75%, benzyl benzoate 1.2%, Peruvian balsam 1.8%, zinc oxide 11.0%, and boric acid 5.0%, plus the following inactive ingredients: bismuth subiodide, calcium phosphate, and coloring in a bland hydrogenated vegetable oil base.

Precaution Prolonged or excessive use of Anusol-HC might produce systemic corticosteroid effects. Symptomatic relief should not delay definitive diagnosis or treatment.

Dosage and Administration Anusol-HC: One suppository in the morning and one at bedtime for 3 to 6 days or until the inflammation subsides. Regular Anusol: One suppository in the morning, one at bedtime, and one immediately following each evacuation.

And for long-term patient comfort...recommend **Anusol®** hemorrhoidal suppositories. Each suppository contains the ingredients of Anusol-HC without the hydrocortisone.

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Morris Plains, New Jersey 07950
ANGP-23 Rev.

What's on your patient's face...

may be more important than his chief complaint

The lesions on his face may be solar/actinic — so-called senile" keratoses...and they may be premalignant.

Solar, actinic or senile keratoses

These lesions may be called by several names, but they usually can be identified by the following characteristics: the typical lesion is flat or slightly elevated, of a brownish or reddish color, papular, dry, rough, adherent, and sharply defined. They commonly occur as multiple lesions, chiefly on the exposed portions of the skin.



Patient P.T. seen on 3/29/67 shows typical lesions of moderately severe keratoses. Note residual scarring on ridge of nose from previous cryosurgical and electrosurgical procedures.*

Sequence of therapy/ selectivity of response

After several days of therapy with Efudex® (fluorouracil), erythema may begin to appear in the area of the lesions; the reaction usually reaches its height of unsightliness and discomfort within two weeks, declining after discontinuation of therapy. This reaction occurs in affected areas. Since the response is so predictable, lesions that do not respond should be biopsied.

Acceptable results

Treatment with Efudex provides highly favorable cosmetic results. Incidence of scarring is low. This is particularly important with multiple facial lesions. Efudex should be applied with care near the eyes, nose and mouth.



Patient P.T. seen on 6/12/67, seven weeks after discontinuation of 5%-FU cream. Reaction has subsided. Residual scarring not seen except for that due to prior surgery. Inflammation has cleared and face is clear of keratotic lesions.*

*Data on file, Hoffmann-La Roche Inc., Nutley, N.J.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local — pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported — insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Solution, 10-ml drop dispensers — containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Cream, 25-Gm tubes — containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

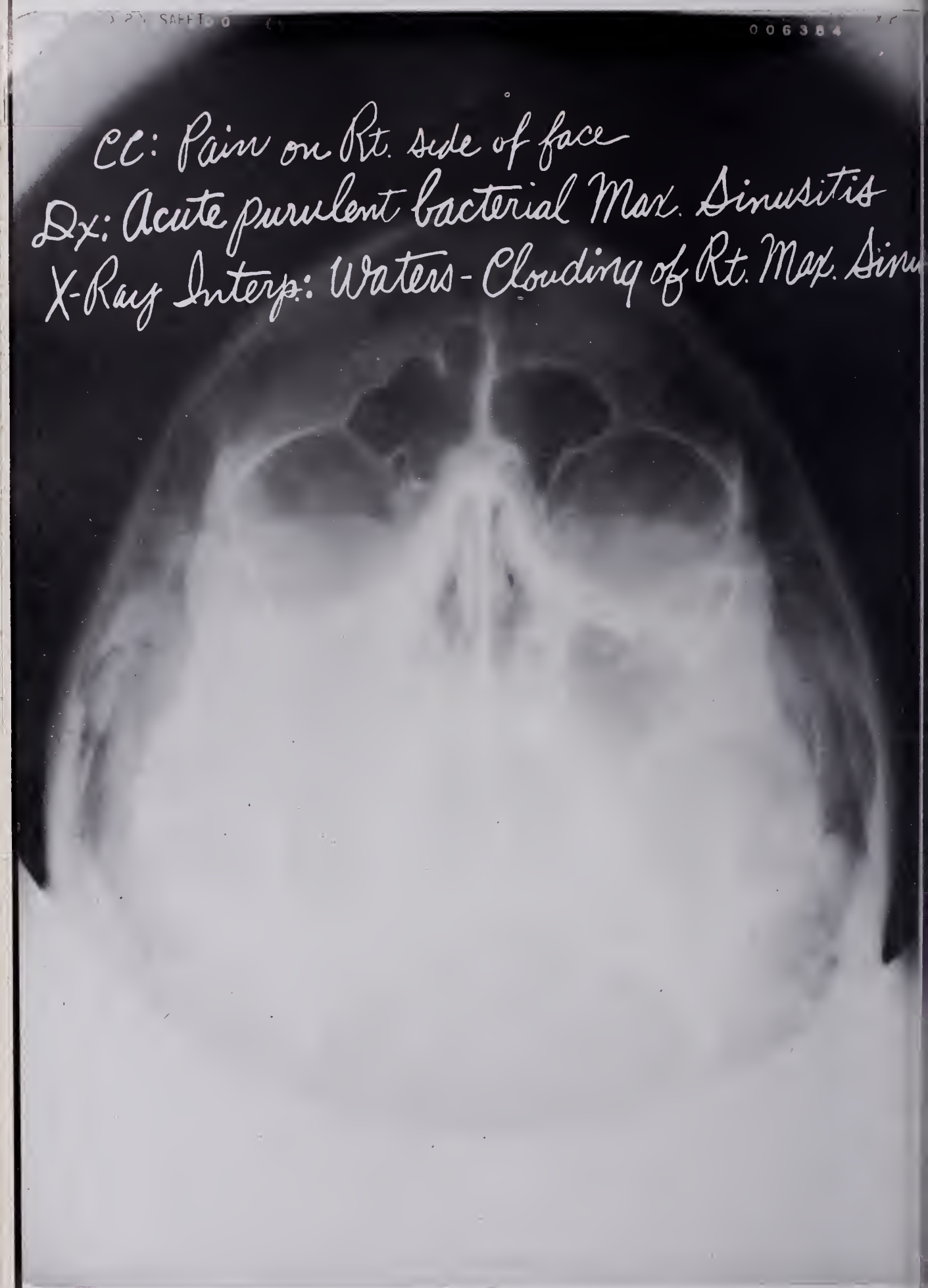
This patient's lesions were resolved with

Efudex® (fluorouracil)

5% cream/solution ...a Roche exclusive

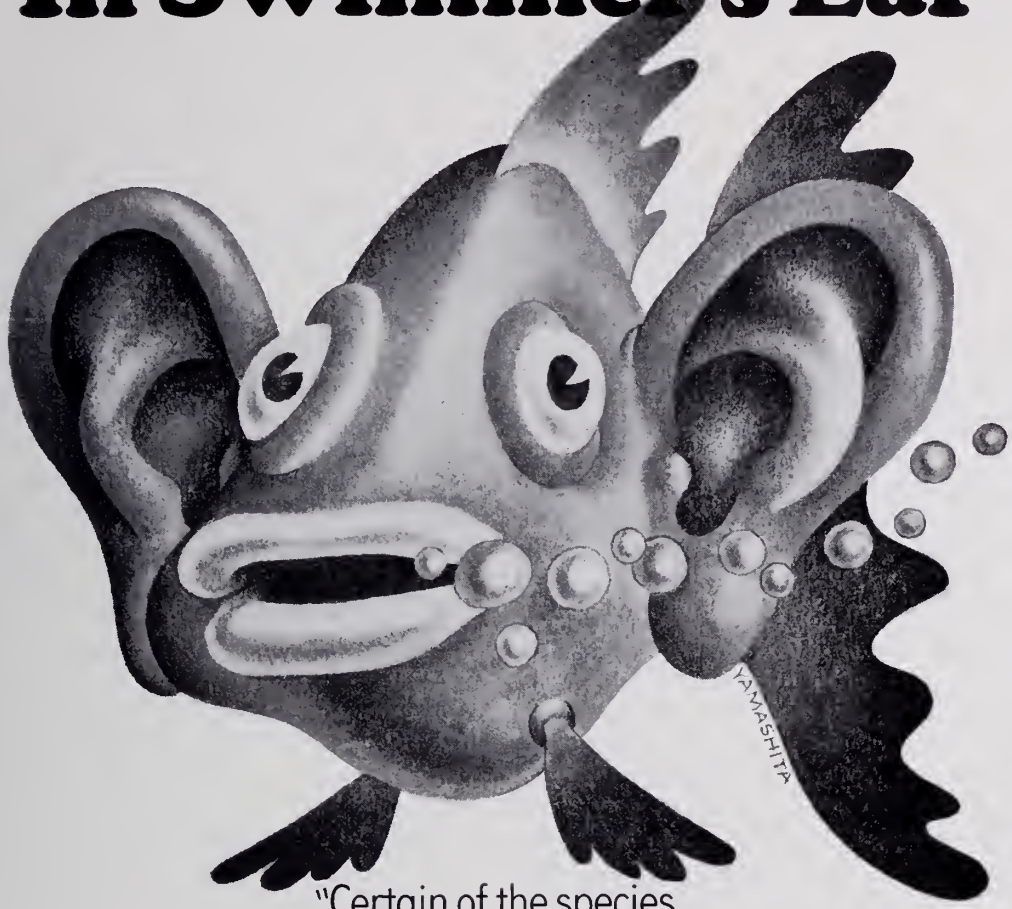
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X-ray provided by Manhattan Eye, Ear and Throat Hospital

In Swimmer's Ear



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are apt to encounter aural
difficulties after engaging in various
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Furacin® Otic

(nitrofurazone) antibacterial/anesthetic/antifungal

Formula: Contoins (w/w) 0.2% FURACIN, brond of nitrafurozone, 0.375% Micafur®, brand af nifuroxime, ond 2% diperodon hydrochloride dissolved in woter-soluble, nondrying, hygroscopic polyethylene glycal.

Indications: For treatment af bacterial otitis externa, bacteriol otitis media and otomycasis. In otitis medio, this preporotion is not effective if the tymponic membrone is intoct.

FURACIN (nitrofurozone) and Micofur (nifuraxime) are active against a variety af grom-positive ond grom-negative orgonisms. Activity versus Pseudomonos sp. is limited to certoin strains. Micafur (nifuraxime) is active against Condido (Monilio) olbicans.

Precautions: Sensitizotion moy occur with prolonged use and is more likely to develop in eczemotous otitis externo. To minimize such reoctions (o) limit opplicotion to o week or less, ond (b) ovoid use of excessive omounts which moy run down the foce.

This preporotion is not indicoted for use in treotment of cholesteotomo, where surgicol intervention is necessary.

Supplied: Bottle of 15 cc. with dropper.

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NORWICH, NEW YORK 13815

Dean's Page

Farewell and Godspeed, Dr. Suter

This is a sad time for the University of Florida College of Medicine because it is losing one of the finest deans American medical education has ever known. Dr. Emanuel Suter, previously Professor of Microbiology, became dean of this college in 1965. Under his direction, an outstanding medical faculty was recruited, and the direction of the whole college was changed.

The curriculum for medical students which he initiated has become a model for many schools throughout the country, involving the exposure of medical students early in their career to patients and clinical disease with focus on specific systems and their abnormalities rather than disciplines and on problems which cut across departmental lines. It is one of the only curricula which, in its continued attempt to provide for medical students that which is most necessary for them, has done away with specific blocks of time for individual departments, and has established teaching which remains flexible and can stress the most important aspects of medicine as they develop. This approach to medical education treats the students as the mature individual he must be if he assumes the care of patients. It permits him early in his career to select special areas of medicine in which to become especially proficient and gives him the flexibility of making his education, under faculty guidance, maximally useful to his future life.

In addition to these educational achievements, Dr. Suter reoriented the whole outlook of the College of Medicine from one of an institution concerned with education, but not with the community, to that of an institution which looks outward to the community. This approach has brought strong ties to health education programs in Jacksonville, Tallahassee, Pensacola, and other areas and has developed Florida as an educational community, with the University as a participant, rather than leaving the University more or less isolated.

Despite its sadness at the departure of such a forward looking and innovative dean, the faculty of the College of Medicine is determined to make even greater efforts to work with and serve the physicians in the community. We look forward to a close association in which we may all participate in educating each other in areas of our own special skills. In addition, we hope to be able to help provide care for that small group of patients that can best be cared for at a university hospital and to work with practicing physicians throughout the state not only in patient care but in the education of our medical students. We look forward to exposing medical students and housestaff not only to the atmosphere of the University Hospital but also to the fine care which they can see practiced by the many physicians in our area. This partnership in patient care and education is one which we will try very hard to foster and develop.

HERBERT E. KAUFMAN, M.D.
GAINESVILLE

Dr. Kaufman is Acting Dean of the University of Florida College of Medicine, Gainesville.

The University of Florida College of Medicine and the Medical Community

When this appears in June, I shall have (had) the privilege of attending a conference in London jointly sponsored by the Josiah Macy Jr. Foundation and the Royal Society of Medicine to discuss "The Greater Medical Profession." In anticipation that the physician in the enlarging health field will assume the key role of planning an education for the delivery of health and medical care to our citizens, it is the aim of the College of Medicine at the University of Florida to develop educational programs which will prepare M.D. graduates for this "greater medical profession;" however, an educational institution such as the College of Medicine cannot accomplish this alone. It needs the cooperation of the practicing profession, and many other agencies as well. Experience during the past few years here in Florida has shown that such collaboration is possible, even if at times difficult and cumbersome. If nothing else, combined efforts and communication establish a climate of understanding and trust and permit a broader input into the decision-making process, although we must realize that it will never be possible to reach agreement on all issues. In general, the professions are more inclined to extend and strengthen the status quo, whereas the medical school often acts as a change agent. A healthy balance of these influences usually leads to the most constructive solution. Domination of one over the other may be expeditious at times, but is often destructive over an extended period of time.

The College of Medicine of the University of Florida has been fortunate that the medical practitioner, organized medicine, and particularly the Medical Advisory Committee have taken partnership roles. I believe the practice of medicine and medical education have profited from this. The most far-reaching success has been achieved in the collaboration between the J. Hillis Miller Health Center and the Jacksonville Hospitals Educational Program. It is anticipated that similar relationships will develop with the educational programs in Pensacola, Daytona, and Tallahassee. In Tallahassee the joint program in the basic medical sciences with Florida State University and Florida A & M University is of great significance. These efforts and their successes have attracted national attention and have placed Florida medicine and medical education in a leadership position. The actual programs are in the process of evolving and should have their impact in the immediate future.

Personally, I have considered it a privilege to serve as Dean of the College of Medicine during this period of evolution. I should like to thank all for their willingness to participate in our efforts and for their personal friendship. My thanks go particularly to the present and past presidents of the Florida Medical Association, to the chairman of the Medical Advisory Committee to the University of Florida, to the present and past presidents of the Florida Academy of Family Practice and to the leaders of the community medical education program. I trust they will extend the same welcome and willingness to collaborate to my successor, Dr. Herbert E. Kaufman, who has assumed the function of Acting Dean. He is equally keen on such a partnership and has the advantage of bringing with him to the deanship successful endeavors in his own field of Ophthalmology.

EMANUEL L. SUTER, M.D.
GAINESVILLE

Dr. Suter will assume the responsibility for international programs of the Association of American Medical Colleges, Washintgon, D. C., June 6, 1972.

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Medical News

New FRMP Director

Mr. Eugene L. Nixon of Jacksonville has been appointed to the Board of Directors of the Florida Regional Medical Program, Inc., as a representative of the Florida Medical Foundation.

H. Phillip Hampton, M.D., of Tampa, President of FRMP, said that Mr. Nixon succeeds Jere W. Annis, M.D., of Lakeland.

Mr. Nixon is Director of the Scientific and Medical Services Department of the Florida Medical Association.

American College of Anesthesiologists

Six Florida physicians have been certified as Fellows of the American College of Anesthesiologists. They are: Allan J. Adeeb, M.D., Jacksonville; Thomas B. Caldwell III, M.D., Miami; James Hugo Drews, M.D., McDill Air Force Base; Jean Thorsen Messner, M.D., Coral Gables; Joseph L. Riley, M.D., Winter Park; and Scott Curtis Stein, M.D., Key West.

Florida M.D. on AMA Task Force

William T. Haeck, M.D., of Jacksonville, has been appointed by the American Medical Association's Board of Trustees to its new Task Force on Hospital Emergency Room Services.

Dr. Haeck was appointed as a representative of the American College of Emergency Physicians. He and eight other physicians named to the Task Force will study the problems of hospital emergency room services and explore alternatives for providing care to nonemergency patients.

Radiology Fellows

Four Florida physicians were elected to Fellowship in the American College of Radiology during the College's 49th Annual Meeting at Miami Beach in April.

They are: Alfred Schick, M.D., Clearwater; Fredie Patrick Gargano, M.D., Miami; Wade S. Rizk, M.D., Jacksonville, and Clyde M. Williams, M.D., Gainesville.

The College's membership now stands at almost 8,000.

New Governor for American College of Physicians

At the annual meeting of the American College of Physicians in April in Atlantic City, Chester Cassel, M.D. of Miami, was installed as Governor for Florida, heading up the 500 members of the College of Florida. He follows the six year term of Donald F. Marion, M.D.

Family Planning Program

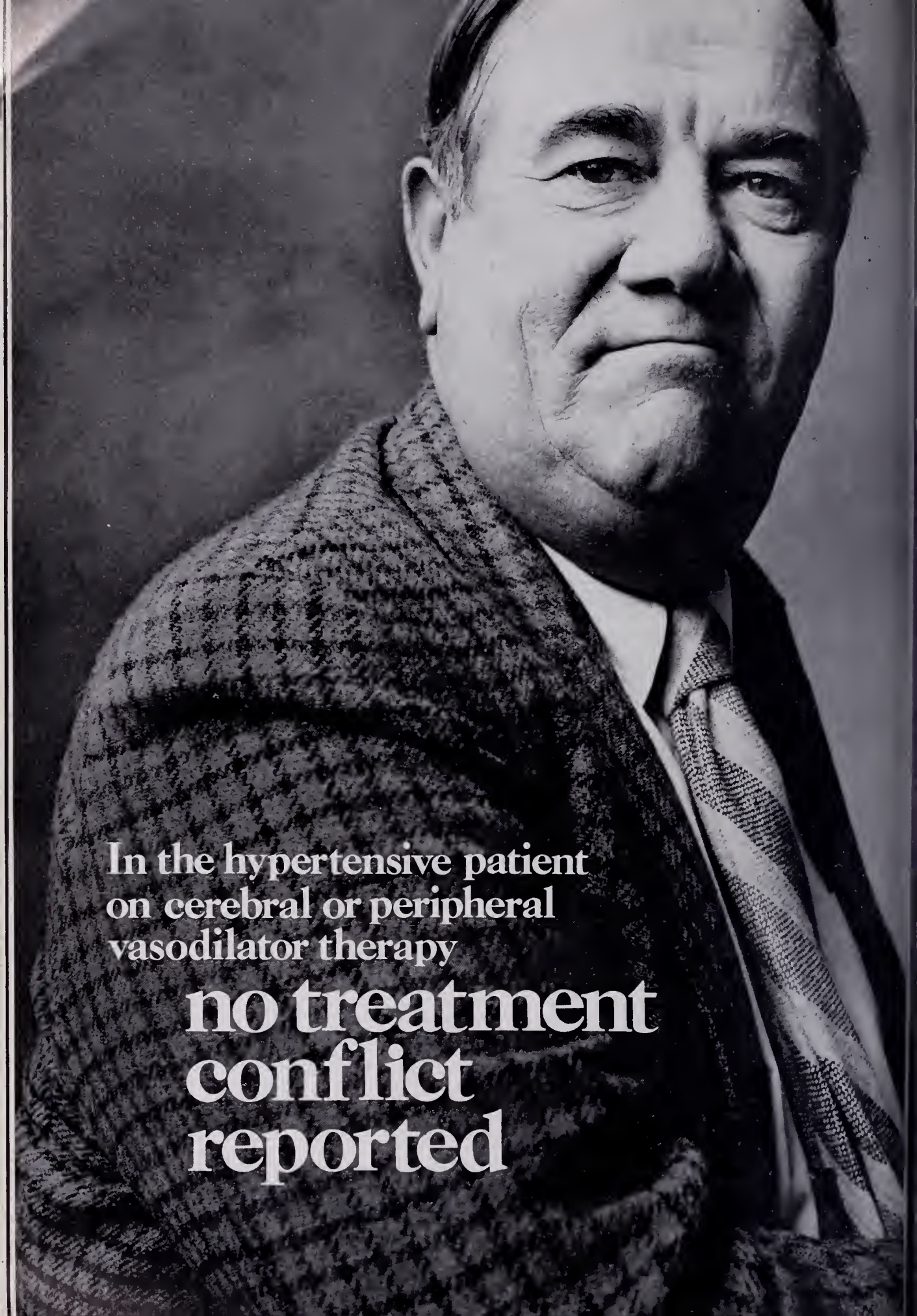
The American Public Health Association has earmarked a grant of $236,000 to the University of Florida College of Medicine for continuation of a family planning program. The program is being carried out among rural poor in 13 north Florida counties.

The Florida allocation originated with the Office of Economic Opportunity who granted a lump sum to the American Public Health Association, who, in turn will allocate it to 12 selected medical schools.

Dr. Davis Is Elected

Joseph H. Davis, M.D., of Miami, has been elected a Vice President of the American Academy of Forensic Sciences. The election came at the Academy's 24th Annual Meeting in Atlanta.

Dr. Davis is Chief Medical Examiner of Dade County and is the current President of the Dade County Medical Association.


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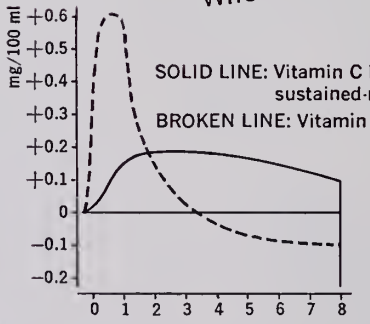


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JUNE, 1972 • VOLUME 59 • NUMBER 6

Arteriovenous Fistula of the Pelvis Following Hysterectomy

Case Report of a Simplified Surgical Treatment

JOHN R. IBACH JR., M.D., PHILIP J. HESS, M.D., FORREST CLORE, M.D., AND MYRON W. WHEAT JR., M.D.

Arteriovenous fistula occurring in the pelvis has been reported often enough so that it is no longer considered a rarity.[1-7] The etiologies of this entity include congenital malformation,[2] trauma, iatrogenic sequella of pelvic surgery, and methotrexate chemotherapy for chorioepithelioma.[4]

The following case report describes the successful surgical treatment of a pelvic arteriovenous fistula which occurred following hysterectomy.

Case Report

A 38-year-old white female was admitted to the University of Florida Teaching Hospital in May, 1970 because of pelvic pain. History revealed that the patient had undergone a transabdominal hysterectomy and bilateral salpingo-oophorectomy nine years earlier. As the result of pelvic examinations following the hysterectomy, she had been told that a vaginal cyst was present on the right side. On physical examination two weeks prior to this hospital admission a pulsatile mass was noted along the right vaginal wall. Because of increasing pain in the region of the mass and dyspareunia of several months duration, the patient was admitted for evaluation and treatment.

Positive physical findings were confined to the abdominal and pelvic examination. There were no palpable abdominal masses, but there was tenderness to deep palpation in the right lower quadrant. The external genitalia and intriotus were normal. Along the right lateral vaginal wall there was a 5 x 6 cm. pulsatile mass with a prominent thrill.

Chest roentgenogram, electrocardiogram, hemogram and urinalysis were all within normal limits. Distal aortogram revealed a large arteriovenous fistula in the right pelvis involving terminal pelvic branching of the right internal iliac artery and tributaries of the right internal iliac vein (Fig. 1 and 2).

Two days later the patient underwent ligation and division of the right internal iliac artery via a right lower quadrant retroperitoneal approach. The postoperative course was uncomplicated and at the time of discharge the mass was still present on the right vaginal wall but it was no longer pulsatile. On subsequent outpatient visits the mass disappeared completely as did the pain and pelvic tenderness. Arteriogram on the eighth postoperative day showed disappearance of the arteriovenous fistula (Fig. 3).

Discussion

The most likely etiology of the arteriovenous fistula in the pelvis of this patient was transfixion suture used to control the vascular pedicle of the uterine artery and vein at the time of hysterectomy. Considering the many thousands of hysterectomies which are done each year using this technique, it is surprising that the incidence of

From the Division of Thoracic and Cardiovascular Surgery and the Department of Radiology, University of Florida College of Medicine, Gainesville.

Supported in part by Graduate Clinical Cardiovascular Training Grant, PHS-5T12HE05850, from National Heart and Lung Institute and the Clinical Fellowship of the Florida Heart Association.

A-V fistula is not higher. Although some authors suggest individual ligation of the artery and vein to avoid this complication, this method does not seem very practicable and in fact could easily be more hazardous. Rather, careful placement of suture ligatures avoiding passage of the needle through both the artery and vein would seem to be a better practice. Even more preferable might be the method of ligation followed by a distal suture ligature.

Regardless of the method used for controlling the uterine vessel pedicle at the time of hysterectomy, pelvic A-V fistula will undoubtedly continue to occur and awareness of the entity and its prompt recognition are imperative.

The presence of a pulsating mass on pelvic examination following hysterectomy should alert the clinician to the possibility that an A-V fistula may be present. The presence of a thrill over the mass and a continuous bruit during auscultation are generally diagnostic. When symptoms occur, they are most likely from pressure on contiguous structures including nerves, bowel and bladder. Also, dyspareunia is a frequent complaint. The lesions are usually sufficiently small so that there are no secondary signs of circulatory system involvement such as increased pulse pressure, pulse rate, high output cardiac failure, etc.

Contrast angiography is essential in establishing the diagnosis and should be undertaken without delay once the entity is suspected clinically. This is easily performed by a percutaneous arterial catheterization of the femoral artery on the side opposite the lesion and injection of contrast in the distal aorta. The exact configuration of the A-V fistula should be well demonstrated and it is helpful to the surgeon in delineating the extent of the lesion. Following surgical repair of the lesion, repeat angiography is advisable to assure that remnants of the lesion are no longer present.

Excision of the arteriovenous fistula is generally accepted as the treatment of choice. However, the lesion may be quite inaccessible as our case illustrates. Invariably, the ureter is in close proximity to the fistula and injury to this structure is a definite threat, especially if excessive pelvic scarring is present. Control of the proximal internal iliac artery and identification of the ureter at a level above the fistula is necessary so that bothersome pelvic bleeding can be controlled by proximal occlusion, and risk of damage to the ureter is minimized. Because of the fibrous reaction about the lesion in our case and intimate involvement with the ureter in the depths of the pelvis, it was felt best to interrupt and ligate the arterial inflow rather than to attempt removing the lesion. Complete excision in this case would have been unduly hazardous and would have necessitated considerable dissection in the depths of the pelvis possibly including removal of a portion of the vaginal wall.



Fig. 1.—Preoperative distal aortogram demonstrating A-V malformation on right side of pelvis (arrows) being fed by terminal branches of internal iliac artery (iia) Contrast is in bladder from earlier injection.



Fig. 2.—Preoperative study (late arterial phase) showing early filling of the iliac veins (iv) from a large draining vein (white arrow) of the A-V malformation. Collateral vessels can be seen from the left side of the pelvis.



Fig. 3.—Postoperative study eight days following operation showing interruption of internal iliac artery (iia) well above pelvic branches. Pelvic A-V fistula no longer demonstrable although collateral flow to the distal portion of internal iliac artery is present from a branch of external iliac artery (white arrow).

Complete disappearance of the thrill following ligation of the internal iliac artery plus radiographic evidence that the A-V communication was no longer present, along with the postoperative disappearance of the pelvic mass support the wisdom of this surgical approach. The extraperitoneal approach, while perhaps somewhat more limited in terms of surgical exposure, afforded adequate visualization of the involved structures and resulted in a completely benign postoperative course.

Summary

A case of an arteriovenous fistula discovered nine years following abdominal hysterectomy in a 38-year old woman is reported. This lesion was demonstrated preoperatively by angiography and was treated by extraperitoneal ligation of the internal iliac artery supplying the lesion. Postoperative angiography showed disappearance of the lesion, and the mass previously felt on pelvic examination is no longer present. The patient has been free of symptoms since operation. This simple direct approach is presented as an alternative method of choice for a lesion which can become a surgical nightmare with attempted complete excision.

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Dr. Ibach, Suite 521, Marshall Taylor Doctors Building, Jacksonville 32207.

What is a Doctor?

After 25 years of debate the executive board of the World Health Organization has agreed on an official description of a doctor: "A person who, having been duly admitted to a medical school duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in medicine and has acquired the requisite qualifications to be licensed to practice medicine (comprising prevention, diagnosis, treatment and rehabilitation), using independent judgment to promote community and individual health."

Submitted by Hugh A. Carithers, M.D. from the Philadelphia Sunday Bulletin, January 23, 1972.

Laparoscopy for the Diagnosis of Unruptured Tubal Pregnancy

Report of Case

Paul W. Oberdorfer, M.D. and Qudratullah Mojadidi, M.D.

Laparoscopy or peritoneoscopy has gained in interest in recent years with emphasis being directed primarily toward its usefulness in evaluating problems of infertility, and chronic pelvic pain and in performance of tubal ligation. Barely mentioned in the many reviews is the value of the procedure in diagnosis of unruptured and tubal pregnancy. Cohen[1] and Neuwirth[2] discuss this briefly and interestingly enough so does Hope[3] in a paper published in 1937. His presentation includes reports of five tubal pregnancies, all of which were ruptured.

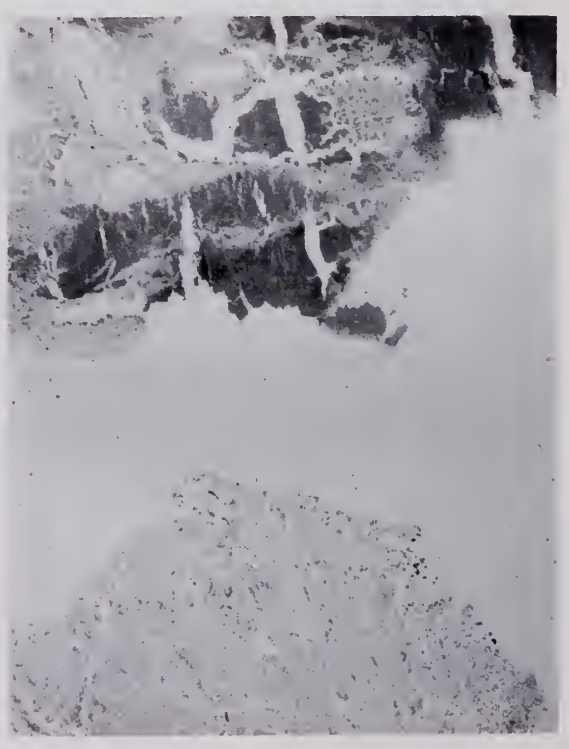


Fig. 1.—Lower third of photograph shows tubal mucosa. Upper third shows blood clot containing trophoblastic villi. (X30).

Ectopic pregnancy as a classic case is diagnosed shortly after rupture with the patient showing evidence of acute pain in the lower abdomen, syncope, and reporting a history of abnormal menstrual periods. Preoperatively the most generally accepted diagnostic method is culdocentesis and one could scarcely argue with its usefulness and simplicity.[4] Unfortunately this procedure does not indicate the diagnosis prior to rupture and development of a hemoperitoneum.

This case illustrates the usefulness of laparoscopy in the diagnosis of unruptured tubal pregnancy.

Report of Case

The 28-year-old married patient was first seen on March 4, 1971 with complaint of involuntary infertility of four years duration. The last menstrual period had occurred on February 6 and since menarche at 11 years of age the periods had been regular. The past history was devoid of any suggestions of pelvic disease, endocrinopathy or metabolic disturbances.

The physical examination was within normal limits except for a retroflexed uterus. Papanicolaou smear of the

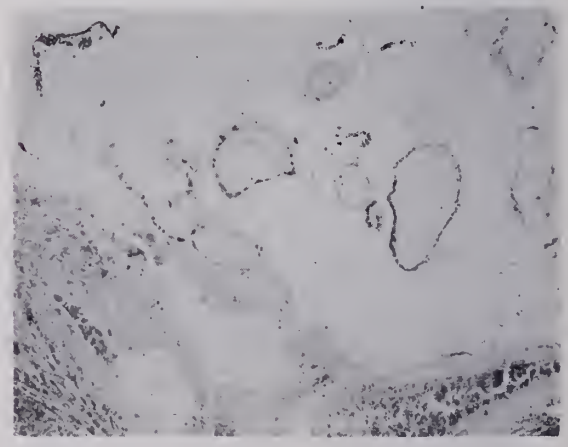


Fig. 2.—Higher power view of trophoblastic villi. (X75).

cervix was Class I and biopsy revealed a secretory endometrium.

A normal menstrual period began on March 5 and continued five days. On March 27 she noted a brown discharge which lasted two days but no pain or pruritus. She was examined again on April 6 and the uterus was soft to the touch, retroverted and slightly tender. On April 14 the Gravindex test showed positive results and five days later the uterus appeared enlarged to a size compatible with six weeks gestation. There was vaginal staining of a red or brown colored material almost continuously but never enough to require a pad. On April 22 she complained of severe pain in the left lower quadrant and left thigh. Examination revealed no significant changes but the patient was admitted to the hospital and laparoscopy scheduled for the following morning.

At laparoscopy the uterus was retroflexed and appeared edematous, the right ovary contained corpus luteum, the right tube was normal as was the left ovary. The left tube was dilated to 2.5 cm. in its middle third and blue in color. Subsequently a left salpingectomy was performed.

Pathological examination of the excised tube confirmed the diagnosis.

The postoperative course was uneventful with no significant change in the patient's hematologic parameters. Morbidity was minimal.

Summary

A case is presented to illustrate the usefulness of laparoscopy in diagnosis of tubal pregnancy prior to rupture with its potentially catastrophic sequelae.

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Doctors Expensive?

A doctor, picking up his car at a garage, was highly indignant at the size of the repair bill. "All this for a few hours' work!" he yelped. "Why, you charge more for your work than we of the medical profession do!"

"Well now," drawled the mechanic, "the way I look at it, we got it coming to us. You guys have been working on the same old model since time began, but we gotta learn a brand new model every year."

—Reader's Digest

Referred Otalgia

Paul L. Goethals, M.D.

Pain in the ear is a frequently occurring symptom which can be exhibited by widely diverse diseases, some serious. If the cause of otalgia happens to be intrinsic to the ear, usually inspection will reveal it. When the ear is not involved, the diagnosis then becomes interesting. The problem resolves itself into that of referred pain. It seems that the patient is conscious of no other structures between the tip of the nose and the external occipital protuberance, in that the pain between these two landmarks is most often assigned to the ear. Thus, he often first seeks the advice of an otolaryngologist. If the cause happens to be a disease at some distance from the ear, it may be overlooked for a considerable period. The patient is thereby started on an "iatrogenic shopping tour" to various physicians and dentists in a desperate attempt to arrive at the exact cause and proper treatment.[1] These patients are often worried about the possibility of "cancer," and their condition may be aggravated by emotional aspects.

It is particularly important that the physician carefully analyze the characteristics of a pain in or about the ear when the cause lies extrinsic to ear structures. Thus he must assess the quality, duration, time relationship, exact location (patient should point with finger), circumstances of modification, and intensity. When pain is referred to the ear from a lesion elsewhere, it is likely that both the ear and the area containing the lesion receive sensory innervation from the same cranial nerve and that spread occurs by way of central connections within the gray matter of the brain stem.[2]

Using the teeth as a source of pain, Robertson et al[3] studied the experimental production of referred pain within the trigeminal area. They concluded that the pain in the head associated with a prolonged toothache, and which was experienced remote from the site of noxious stimulation in the tooth, was of two varieties: (1) that due to central spread of excitation and experienced in tissues supplied by the same and adjacent divisions of the fifth cranial nerve, and (2) that due to sustained contraction of the muscles of the head and neck resulting secondarily from noxious stimuli arising in the teeth. Referred pain in other regions of the body is familiar to clinicians. For example, the pain produced by diaphragmatic pleurisy is felt in the shoulder region and we speak then of "referred pain" in the shoulder. Pain of cardiac origin is felt not only in the precordium but also often down the inner side of the left arm and into the little finger. In this case, the sensory nerves from the heart (through the cardiac sympathetic plexuses) terminate on the first and second cervical segments of the cord, together with afferents from the skin and deeper tissues of the medial aspect of the arm. One also recalls examples of referred pain from abdominal organs to segmental areas of the abdominal wall. Thus the pain "spreads" from one area to another through nerve branches which have a common central origin within the same segments of the gray matter of the spinal cord.[2]

In this paper we will not mention all of the various general theories of referred pain. Some authors have suggested the existence of axon branching among the sensory pathways conveying the sensation of pain.[4] This theory suggests that the branching is of such a type that one limb of a branched axon passes to the site of origin of the disturbance, and others pass to the sites to which the pain is referred.

In the following brief outline are the chief disease categories that might be considered in the differential diagnosis of otalgia.

Ear

1. Otitis media and myringitis
2. Otitis externa (all types)
3. Perichondritis—auricle
4. Tumors of auricle, external canal or middle ear (benign and malignant)
5. Mastoiditis (and complications)
6. Traumatic lesions (injuries)
7. Otitic barotrauma
8. Foreign bodies in ear
9. Excessive cerumen

Mouth and Tongue

1. Tongue inflammation, ulceration and neoplasms
2. Neoplasms, ulceration and inflammation of other oral cavity structures (e.g., palate, gingiva, floor of mouth)
3. Trauma

Pharynx

1. Acute pharyngitis and tonsillitis
2. Peritonsillar abscess
3. Parapharyngeal and retropharyngeal abscess
4. Post-tonsillectomy and adenoidectomy
5. Acute nasopharyngitis
6. Lingual tonsil infection or tumors
7. Ulceration or neoplasms of nasopharynx, oro- or hypopharynx
8. Glossopharyngeal neuralgia
9. Elongated styloid process
10. Palatine tonsil tumors

Teeth and Mandible

1. Impacted molar teeth and erupting teeth
2. Dental caries
3. Apical abscess and other odontogenic infections (e.g., pericoronitis)
4. Malocclusion
5. Arthritis and dysfunction of the temporomandibular joint
6. Trauma
7. Tumors of the mandible

Sinuses

Inflammation and neoplasms of the maxillary, posterior ethmoid or sphenoid sinuses (some instances)

Larynx and Trachea

1. Neoplasms and ulcerations of the larynx or trachea
2. Acute laryngitis, trauma, foreign bodies
3. Some unusual diseases involving larynx (for example: pemphigus and tuberculosis)

Glands

1. Salivary gland infection or abscess (parotid or submaxillary glands)
2. Calculi (stones) of salivary glands or ducts (commonly of Wharton's duct)
3. Salivary gland neoplasms, trauma
4. Acute thyroiditis and thyroid tumors

Intracranial

1. Middle fossa extradural abscess
2. Occasional tumors or localized meningitis of the base of the skull (e.g., tumors of the cerebellopontine angle)
3. Intracranial aneurysm

Facial Nerve

1. Herpes zoster oticus (including Ramsay Hunt syndrome)
2. Bell's palsy
3. Geniculate neuralgia (primary)
4. Tumors of the facial nerve

Neck

1. Cervical spine lesions (arthritis, infection, disk lesions, tumors and trauma)
2. Other neck neoplasms (primary, metastatic)
3. Cervical lymphadenitis and abscess
4. Carotid pain (autonomic imbalance)

Miscellaneous Group

1. Cranial arteritis
2. Vascular headaches
3. Muscle tension, fibrositis and myalgias
4. Some chest lesions (e.g., reflux esophagitis)
5. Other neuralgias (e.g., trigeminal, postherpetic, psychogenic)

Nerve Supply

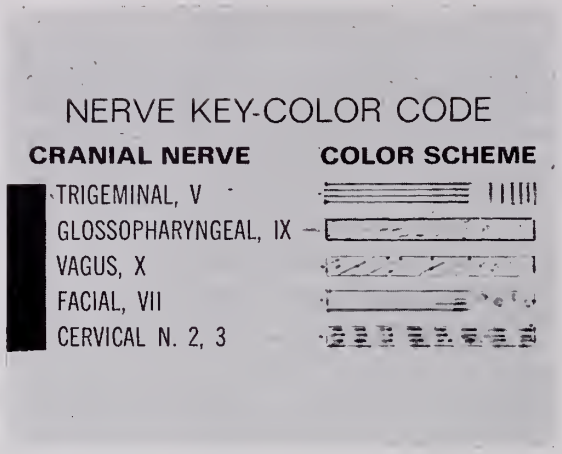
The nerves involved in referred otalgia are the 5th, 7th, 9th and 10th cranial nerves and cervical nerves 2 and 3.[5,6] Because of the overlap between adjacent cutaneous nerves, the exact distribution to the auricle and the external canal is not known. However, the approximate sensory innervation is as follows (Figs. 1-3).

The auriculotemporal branch of the mandibular division of the 5th cranial nerve is distributed to the most anterior part of the auricle, the anterior and upper walls of the external auditory canal, and a corresponding portion of the external surface of the tympanic membrane.[7] Most of the posterior (medial) surface of the auricle, and the posterior portion of the lateral surface (including the lobule) is supplied by the cutaneous branches of the cervical plexus, primarily the great auricular nerve from C2 and C3. The lesser occipital nerve (also C2 and C3) supplies the skin over most of the mastoid region, and also on the upper medial part of the auricle. Sensory fibers of the 7th, 9th, and 10th nerves, reaching the ear through the auricular branch of the vagus (Arnold's nerve), supply the concha and the posterior portion of the external canal and drum membrane (external surface). These nerves also are distributed to a small area of skin on the posteromedial aspect of the auricle and adjacent mastoid region[5] (Fig. 2).

The innervation of the external surface of the drum membrane is from the auriculotemporal branch of the 5th and the auricular branch of the 10th (or 7th, 9th, and 10th) nerves, corresponding to the innervation of the external canal (Fig. 3). The innervation of its inner surface is from the tympanic plexus (largely the 9th nerve).[5,8]

The nerves of the middle ear are represented by the tympanic plexus, which is formed mainly by the tympanic branch (nerve of Jacobson) of the 9th cranial nerve[9] (Fig. 3). Hunt[10] suggested that sensory branches from the facial nerve also may join the tympanic plexus. The sensory supply to the eustachian tube is largely also by way of the tympanic plexus (9th cranial nerve). Erickson[11] found complete anesthesia of the tube following an intracranial section of the glossopharyngeal nerve for paroxysmal neuralgia. Dandy[12] and Stookey[13] noted that the orifice of the tube is included in the area of supply by the 9th cranial nerve.

The corresponding sensory innervation of the mouth, tongue and pharynx is illustrated in Figure



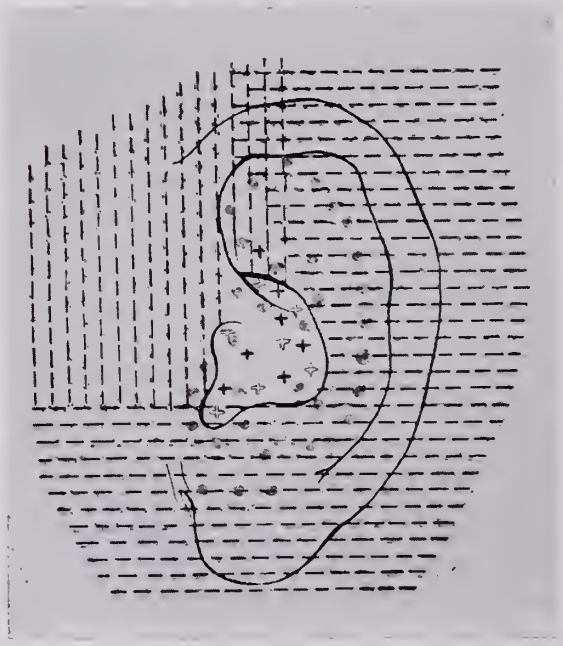
4. The nerve-key (color code) is included to aid the nerve identity and comparison in both the ear and these possible lesion areas. The main sensory nerve supply to some areas not illustrated is given in Figure 5.

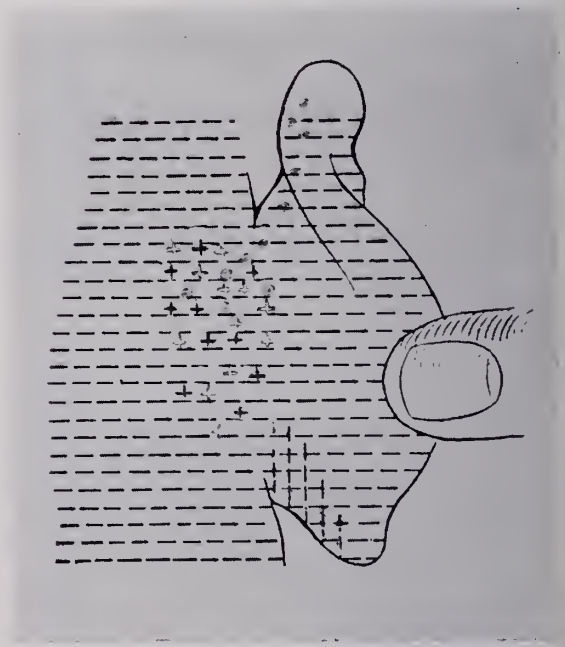
Discussion

When a patient complains of an "earache" or pain near the ear, in the presence of normal ear structures, a number of other (extrinsic) sources should at once come to mind. To focus further on the lesion site, the physician must ask every detail about the "earache." This includes the determination as to whether the pain is initiated or aggravated by chewing, swallowing, speaking, coughing or various head and neck movements or positions. It is often helpful to have the patient place a finger exactly on the site of pain. The physical examination should be performed in a thorough, systematic manner, including the entire head, neck, chest and respiratory tract. The nasopharynx, hypopharynx and larynx must be carefully inspected, usually by indirect mirror examination. Digital palpation of the tongue, palate and tonsils is an essential part of this survey.

Roentgenograms are often vital to establish the correct diagnosis. In the search for cryptic lesions as the source for otalgia, the physician must consider roentgenograms of the chest, larynx, esophagus, sinuses, skull, mastoids, cervical spine, mandible (and teeth), temporomandibular joints, salivary glands and ducts, and (rarely) styloid processes. Special x-ray techniques, such as tomography are often necessary to define a lesion.

Isolated cases have been reported of infection in the posterior ethmoid cells or sphenoid sinus giving rise to referred pain to the ear, but this is not the usual history.[2] One of the most common causes of otalgia is that of dental origin. Besides dental caries, it should be recalled that unerupted or impacted wisdom teeth, and odontogenic infections such as apical abscess and pericoronitis may be the source. Consultation with the dentist is of course important in these instances. Malocclu-





Figs. 1 and 2.—Cutaneous innervation of the ear on the lateral and posterior aspects. (From Hollinshead, W. H., Anatomy for Surgeons, vol. 1, The Head and Neck, Second Edition, New York, Hoeber Medical Division, Harper & Row, Inc.—1968). Color code adapted for nerve identity.

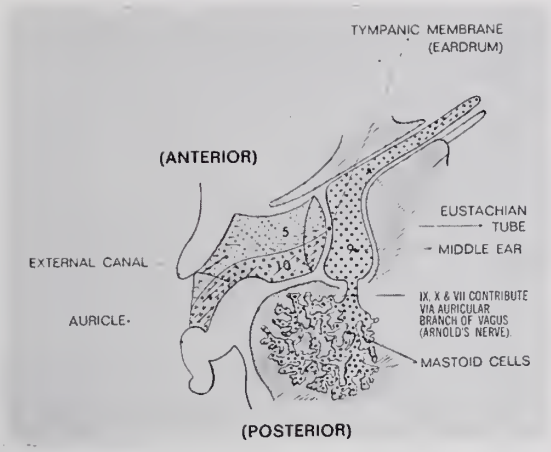


Fig. 3.—Sensory nerve distribution to the external auditory canal, tympanic membrane and middle ear (horizontal section diagram) (From Hollinshead, W. H., Anatomy for Surgeons, vol. 1, The Head and Neck, Second Edition, New York, Hoeber Medical Division, Harper & Row, Inc.—1968). Color code adapted for nerve identity.

sion of the teeth may also produce pain in the ear. In this instance, otalgia may be a result of abnormal pressure of the condyle on the moveable anterior cartilaginous portion of the external meatus or from secondary muscle spasm in this area.[2,14] Arthritis or dysfunction of the temporomandibular joint should also be considered. Costen[15,16] found otalgia to be the commonest complaint in cases of dysfunction of the temporomandibular joint. It has been suggested that some pain associated with so-called "Costen Syndrome" may be explained by a "myofascial trigger mechanism."[17]

An interesting (but rare) possibility in the underlying cause of earache is an elongated styloid process; however many of these patients are asymptomatic. When present, the otalgia is caused by irritation of the glossopharyngeal nerve, which is in close proximity to the styloid process.[18]

Politzer made the statement that "if symptoms of a pharyngeal or laryngeal affection are present, we must ascertain by careful examination whether the pain in the ear is not due to these conditions."[19] The patient with a lesion of the epiglottis or the pyriform sinus will often complain of an earache on the involved side. The reference is through the superior laryngeal branch of the vagus. Another rare cause of earache is an intracranial aneurysm.[20] Otalgia may occur close to the onset of Bell's palsy and is usually present in severe form in cases of herpes zoster oticus. Most rare as sources are (primary) geniculate

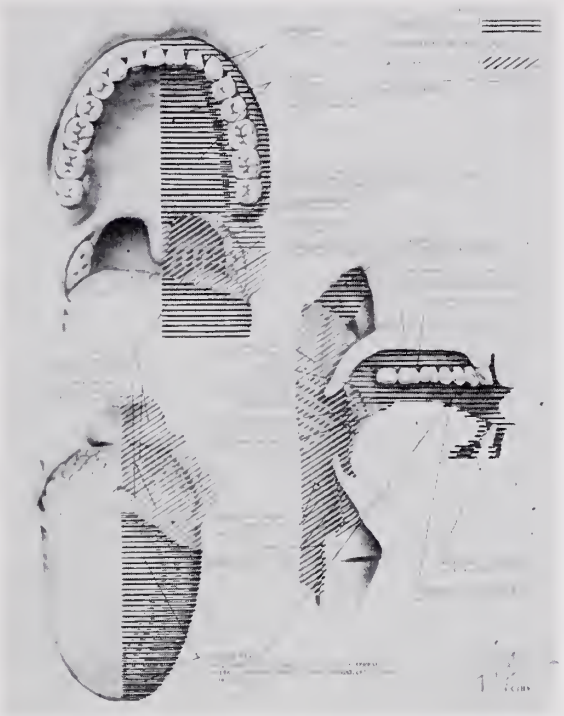


Fig. 4.—Diagram of approximate areas of sensory supply of the oral cavity, tongue and pharynx. Copyright 1959, CIBA Pharmaceutical Company, reproduced, with permission, from The CIBA Collection of Medical Illustrations by Frank H. Netter, M.D.

neuralgia[21,22] and some tumors of the facial nerve.[23] Cervical spine lesions may exhibit otalgia (cervical nerves 2 and 3). Anterior neck and chest lesions are believed to produce pain at or near the ear by way of vagus nerve irritation.

It is interesting that some remote chest lesions can exhibit themselves as pain in or close to the ear. For example, hiatus hernia with reflux esophagitis[24] and lobar pneumonia[20] have been

LESION SITE	MAIN SENSORY NERVE(S)
PAROTID GLAND	TRIGEM., V (VIA AURICULOTEMPORAL NERVE)
THYROID GLAND	VAGUS, X (VIA SUPERIOR LARYNGEAL N.)
BRAIN (MIDDLE FOSSA)	TRIGEM., V (VIA MIDDLE MENINGEAL NN)
NECK (CERVICAL SPINE)	CERVICAL NN 2, 3
SINUSES (MAXILLARY, POST. ETHMOID)	TRIGEM., V (MAXILLARY BRANCH)

Fig. 5.—The main sensory nerves for some areas in which lesions might induce referred otalgia.

described as rare sources of earache. Hilar extension of bronchogenic carcinoma may produce pain near the ipsilateral ear. Although many types of neuralgias and "headaches" are not localized to the ear, some of them occasionally include this structure ("miscellaneous group" in outline).

One must not forget that an autonomic nervous system imbalance along a carotid artery may induce otalgia. This pain may originate from dilatation of any carotid arterial segment, and a common site is at the bifurcation. Thus the patient may complain of an earache and a tender "gland" in the neck. Here the bifurcation is often palpable as a firm, pulsatile and extremely tender mass at the hyoid level.[25]

Summary

Otalgia may be caused by a myriad of diseases, many even remote from the ear. Often terrifying for the patient, this symptom will not be relieved until the underlying cause is discovered and treated. In many such instances, the patient is unable to do more than assign the pain to the general area of the external ear. The nerves responsible for ear area pain are cranial nerves 5, 7, 9 and 10, and cervical nerves 2 and 3. The exact location of referred pain in the region of the ear is determined by the particular nerve involved at the site of the lesion and the sensory innervation from that nerve to the ear area.

In cases of unexplained otalgia, the physician is well advised to carefully investigate the entire head, neck, chest and respiratory tract.

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Foreign MDs Enter U. S. at Increasing Rate

A total of 10,947 foreign trained physicians entered the United States in the year ending last June 30th. The figure represents more MDs than were graduated from all the Nation's medical schools and was 2,424 more than the previous year. The output of American schools was 8,974 according to the Association of American Medical Colleges. A total of 5,756 foreign MDs came to the U.S. as permanent residents. The remaining 5,191, mostly interns and residents, came in on a temporary basis for training in U.S. Hospitals. The total number represents the equivalent of the output of 132 medical schools, or 24 more than there are in this country. The Department of State has notified 975 hospitals that employ the 15,000 foreign medical graduates, that henceforth the Commission on Foreign Medical Graduates will issue certificates of eligibility for exchange visitor status. These are certificates which authorize U.S. consuls to issue visas for admission to the United States.

Report of Cardiovascular Screening of Florida Physicians

M. E. Groover Jr., M.D., J. E. Fulghum, M.D., and Wm. W. Mahoney, M.P.H.

A cardiovascular screening service was provided for physicians attending annual meetings of the Florida Medical Association in 1970 and in 1971 by the Florida Division of Health with the assistance of the University of Florida College of Medicine, Southern Bell Telephone Company, and Marquette Electronic, Inc.

Procedure

The procedure was the same as that used by county health departments operating screening programs in cooperation with county medical societies.

Identification data along with height and weight were noted. Blood pressure was measured and an EKG tracing recorded. The signal was transmitted to the Computer Science Department at Shands Teaching Hospital in Gainesville, where it was analyzed, and the results returned to the screening center by teletype.

An abbreviated history was recorded and blood was obtained for chemical analyses at the central laboratory of the Division of Health in Jacksonville. The blood was examined for sugar, cholesterol, triglycerides, uric acid and hemoglobin.

In 1970, 61 physicians and eight wives and members of their families were screened. In 1971, 73 physicians and 31 wives and family members were screened. More requested screening but the service was limited by exhibit hall hours and certain elements of the procedure which were unduly slow. The transmission of EKG signals was unusually time consuming and proved to be the main bottleneck. If EKG tracings are recorded in rapid succession it should be possible to screen 60 or 70 persons per day. While computer interpretation of the tracing was interesting, it was not the main attraction. Practically everyone waited for a physician to review the tracing and confirm the computers analysis. Most physicians appeared more interested in the report of blood lipids than other abnormalities.

Tabulations of Physicians and Attendants in the Cardiovascular Screening Program at Florida Medical Association Meetings 1970-1971.

	1970		1971		
TOTAL	69		104		
PHYSICIANS	61		73		REFERRAL LIMIT
OTHERS	8		31		
AGE	26 Yrs. to 71 Yrs.		25 Yrs. to 86 Yrs.		
	RANGE	NO. ABNORMAL	RANGE	NO. ABNORMAL	
Weight	100 to 265	11 (16%)	107 to 265	6 (5.7%)	P.I. Above 9*
Pulse rate	52 to 128	2 (3.3%)	58 to 108	1 (.9%)	Above 100
Systolic B.P.	104 to 180	8 (13.1%)	100 to 200	9 (8.6%)	Above 160
Diastolic B.P.	55 to 105	10 (16.3%)	62 to 118	6 (5.7%)	Above 90
EKG	54 — Norm.	15 (24.6%)	84 Norm.	20 (19.2%)	All abnormal
Family Hist. of H.D.	33 Neg.	36 (59.0%)	48 Neg.	55 (52.8%)	All with pos. history
Personal Hist. of H.D.	63 Neg.	6 (9.8%)	89 Neg.	15 (14.4%)	All with pos. history
Cigarette smoking	17 Never 26 Quit	26 (42.6%)	51 Never 30 Quit	23 (22.1%)	All cigarette smoking
Blood sugar	80 to 158	14 (22.9%)	83 to 253	9 (8.6%)	Above 150
Cholesterol	154 to 300	9 (14.7%)	148 to 300	26 (25.9%)	Above 250
Uric Acid	2.6 to 8.3	13 (21.3%)	2.1 to 9.6	36 (34.6)	Above 6.9
Triglyceride	40 to 396	15 (24.6%)	40 to 500	17 (16.3%)	Above 200
Hemoglobin	11.7 to 16.9	0 (0?)	11.3 to 17.7	7 (6.7%)	Above 16.9

*Ponderal Index $= \sqrt[3]{\text{WT.}} \div \text{HT.} \times 100$

Results

The results of the screening tests have been tabulated in the accompanying table.

We have arbitrarily set limits of normality that may not be valid in certain circumstances. We decided that a person of 72 inches weighing 225 pounds is the upper limit of normal. The ponderal index of this person would be 8.45. Those with a ponderal index above nine are tabulated as abnormal (cube root of weight divided by the height times 100= Ponderal Index.

A pulse rate above 100, systolic blood pressure above 160 mm. Hg. and diastolic blood pressure above 90 mm. Hg. were considered abnormal.

Any abnormality of the EKG was considered abnormal. All the changes detected were old or static abnormalities. None indicated recent myocardial damage.

The family and personal histories of heart attacks, both used in tabulating the information for county health departments, were used in this group when evaluating the complete screening data for each individual.

It is of interest to note the number of physicians who continue to smoke cigarettes (see table).

A blood sugar above 150 mg.% was considered abnormal even though most screenees had eaten breakfast only one or two hours before the test. Twenty three percent of those examined in 1971 had abnormal blood sugar compared to 8.6% in 1971.

An elevation in blood triglycerides is expected to accompany diabetes and all those with elevated blood sugar had triglycerides above mean normal of 150 mg.%. Twenty four percent of those in 1970 and 16.3% of those in 1971 had triglyceride values above 200 mg.%.

From other data accumulated in county cardiovascular screening programs, we found that almost 70% of patients with elevated triglycerides have fasting blood sugar above 110 mg.%. Many have reduced both triglycerides and blood sugar levels by adhering to a strict weight losing diet; however, others with hypertriglyceridemia and a slender body build have actually shown an increase in triglyceride with starvation.

The highest blood cholesterol was 300 mg.% in both 1970 and in 1971. The person was not the same. Nine or 14.7% of those in 1970 and 26 or 25% of those in 1971 had blood cholesterol values above 250 mg.%.

Discussion

Since the immediate death rate from myocardial infarction is approximately 40%, our only opportunity to treat these patients is to start prophylactic measures before the attack occurs. Being forewarned of the risk factors—abnormal EKG, elevated blood pressure, hypercholesterolemia, elevated hypertriglyceridemia, hyperhemoglobinemia and cigarette smoking—should give us a chance to start the treatment before it is too late.

It is interesting that physicians, like most patients, are willing to make the necessary sacrifice to reduce their chances of having a heart attack or stroke if they are informed of the need for it in some specific way.

In the cardiovascular screening program adopted by the medical societies in 15 counties, we find that patients identified as being in the high risk group will make the sacrifice of time and money to have their physicians guide the prophylactic treatment. On the other hand, it is very difficult to motivate a well and apparently healthy person to stop his busy routine and seek medical assistance for a disease he cannot see or feel and knows very little about. The physicians availing themselves of the service seem to have the same philosophy.

We have written each physician explaining the screening data. Many have replied by telephone and letter that improvements have been achieved in the conditions reported. The program was successful judging from the response.

If members of the Florida Medical Association wish to continue this service, we will plan to insure an adequate staff to screen them at a much faster rate and hopefully will be able to accommodate all those who apply.

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Special Article

Folk Medicine in Florida

Alice H. Murphree, M.A. and Mark V. Barrow, M.D., Ph.D.

In 1965 a northern Florida county with a population of 3,000 but without a physician or hospital was surveyed. A lack of preventive medicine practices and a common tendency to try various methods at home before seeking medical attention was found.[1]

While the use of patent medicines was the common mode of self-treatment especially utilized, possibly as a result of TV advertising,[1] folk remedies also played a part.[2,3] This report concludes our studies on folk remedies in this population.

Eighty-eight households were interviewed and 11% of the sampled respondents admitted current although infrequent use of folk medicines while 70% acknowledged use in the past and 27% were able to supply at least one "old-timey" recipe. In all some 66 references to folk medicines for 31 different complaints were elicited (Table 1). Later, samples of 40 species of local plants and herbs were obtained and identified at the Herbarium of the University of Florida.*

We have divided these preparations into two groups. Table 2 lists the folk remedies with a possible scientific basis (29 of 40 preparations) as suggested by various books and articles[4-22] while Table 3 gives those about which we could find no information in the literature. This tabulation is an expansion of preliminary papers.[2,3]

It should be pointed out that these remedies and beliefs were passed down by word of mouth. Many seem to have been initially learned from the Indians, including the poke plant, black root, trumpet plant, sumac, sassafras and perhaps others. Still others long have been part of European folk tradition possibly originating in prehistoric Mediterranean and Near Eastern cultures.

Although folk medicine is historically much in the tradition of this population, increasing sophistication has made it less socially acceptable to admit knowledge of or belief in "old-timey" remedies. Residents knew that the value of folk medicine is minimized, if not discredited, by orthodox medicine and when both orthodox and folk medicines were discussed in the same conversation they were sufficiently uncomfortable to deny much of their folk knowledge or folk beliefs. However, field experiences showed that interviews focusing solely on folk medicine and couched in nonthreatening terms were highly productive of specific esoteric information.

The fact that no respondents reported folk medicine usages to their physicians was readily understandable in light of their stating that physicians tend to discount the "old timey remedies." The doctors of adjacent rural areas who were interviewed[1] generally agreed that they saw little evidence of the usefulness of the folk medicines and said patients rarely, if ever, discussed them. All knew their patients probably used such practices frequently but felt that maximum use was within the Negro population. While this may be

Table 1.—Frequency of References to Folk Medicine and Other Remedies in the Treatment of Specific Complaints.

	Complaints	Frequency of References
1.	Arthritis	1
2.	Bleeding	2
3.	Chills and fever	5
4.	Colds	6
5.	Colic	1
6.	Cramping	1
7.	Diabetes mellitus	2
8.	Diarrhea	1
9.	Erysipelas	1

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*By Drs. D. B. Ward and D. Burch.

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10.	Gall bladder	1
11.	High blood (pressure)	1
12.	Hives	3
13.	Infection	3
14.	"Low Blood" or "Run Down" (anemia)	4
15.	Malaria	3
16.	Measles	3
17.	Miscarriage	1
18.	Pain	1
19.	Piles	1
20.	Rheumatism	1
21.	"Risins" (boils)	3
22.	Ring Worm	1
23.	Sore Eyes (conjunctivitis)	2
24.	Sprains	3
25.	Stomach trouble, nervous stomach upset stomach, vomiting	6
26.	Teething	2
27.	"Trash" (thrush)	1
28.	Toothache	1
29.	Warts	2
30.	Whooping cough	2
31.	Worms	1
	Total	66

a valid assumption for their total practices, the population of the county studied is approximately 90% white and indications are strong that folk medicine is widely known among both whites and Negroes.

Some Current Folk Beliefs of the Rural County

In addition to the use of herbs and roots, there were three "cures" referred to as "conjurin" which combined verbal formulas, various environmental ingredients, admixtures of religious terminology or texts. A few individuals were credited with possessing the esoteric conjuring knowledge which, to retain their "power," could be shared only with a member of the opposite sex.

Not only remedies per se but many extant folk beliefs influenced other life situations. These include a cluster of beliefs about conception such as sexing the child prenatally, "marking the baby" (maternal impressions), talismans for "easy birthing," predicting future conceptions and controlling "afterbirth" pains. These are more fully discussed elsewhere.[23] For example, one informant strongly avowed that the side to which the female turns following intercourse will determine the infant's sex. This belief has origins at least as far back as ancient Greece.

Other folk beliefs were also prevalent. Relative to mental health, for example, there was a common belief concerning the presence or absence of "the coating on the nerves." Several respondents discussed such folk beliefs as "the signs" (of the Zodiac) which are consulted concerning many activities, including health. One woman reported that castor oil was equally effective as a laxative when rubbed on the abdomen as when "taken." In three households it was difficult to direct the interview away from folk subjects because the field researcher (AHM) was known by reputation to have shown interest in "old timey remedies" during previous field work.

Comment

It is apparent from this study on rural medicine in Florida that folk practices are not dead. In spite of medicine's technical advances, certain cultural groups of this continent still believe in and employ, with varying frequencies, what might be called somewhat primitive forms of medicine. Initially these practices were couched in various folk remedies although this agrarian area's present medical modus operandi, influenced strongly by past folkways, has gradually evolved into the common use of patent medicine, "TV medicine," and recently in prescribed medications. To a lesser extent folk remedies are still used. When we consider that folk beliefs inherently express a way of life, this phenomenon aptly demonstrates the anthropological concept of the adaptiveness of culture.

Other examples indicate that old beliefs may evolve to fit into current practices. For instance, in certain Negro families in Jacksonville, Florida, the use of disposable diapers is common. The belief is held that these are to be discarded but not burned as burning the diapers "will cause the baby to develop a diaper rash."[3] The homeopathic magic analogy is obvious here.

Some prevalent folk beliefs are extant elsewhere than in Florida. In the old order Amish in Johnson County, Iowa,[24] Brauche (or powwow) is used. This involves the silent recital of certain phrases over the sick person. By and large, folk medicine has been replaced by patent as well as chiropractic medicine. In our study of a north Florida rural county there were no reasonably close chiropractors (or, in local idiom, "feeling doctors") which likely explains the lack of comment about these. Iowa, however, is different and, interestingly, the Amish place much more "faith" in chiropractors than in physicians. Generally, they first try various home remedies not too unlike the ones discussed from Florida (excepting, of course, many indigenous plants). If these fail, help from the chiropractor is sought and as a last resort the physician is visited. As they say, "The causes and his results are more permanent."[24] Amish folk beliefs also include support of mater-

TABLE 2.—FLORIDA FOLK MEDICINES WITH SOME POSSIBLE SCIENTIFIC BASIS.

	SCIENTIFIC NAME	COMMON NAME	USEFULNESS ACCORDING TO COUNTY RESIDENTS*	USEFULNESS ACCORDING TO THE LITERATURE	REFERENCES
1	*Allium cepa*	Onion	Roasted onion juice for earache (2)	Juice antiseptic; useful in earache	18, 21
2	*Aristolochia serpentana*	Virginia snake root	Tea to purify or build up the blood (2)	A stimulant; tonic; antitumor activity	4, 6, 7, 20, 20
3	*Asclepius humistrata*	Milkweed	Sap removes warts (1)	Contains asclepiadin; for headache; for ringworm	5, 13, 17
4	*Brassica oleracea*	Cabbage	Wilted leaves draws poison from infected cuts (1)	Useful for carbuncles	21
5	*Cephalanthus occidentales*	Buttonwood	Root in whiskey for dropsy; for asthma (2)	Contains glucoside cephalanthin; for fever	4, 5
6	*Chenopodium ambrosiodes*	Jerusalem Oak	Burned leaves smoke for asthma; root syrup for tonic; tea or syrup for worms (3)	Anthelmintic; contains chenopodium oil	4, 5, 7, 9, 15
7	*Chlous clauca*	Stargrass	Root tea as laxative (2)	Laxative and emetic	4
8	*Chrysopsis graminifolia*	Gopher or fever grass	For gout, rheumatism; boils; ground itch; for cuts (8)	Fever grass	20
9	*Eupatorium compositifolium*	Dog fennel	Root tea for fever (1)	A diaphoretic; for colds and fever	4, 5, 6, 10, 15
10	*Juglans nigra*	Black walnut	Soak feet for ground itch (1)	Contains calcium oxalate	5
11	*Myrica cerfera*	Low bush myrtle	Tea to maintain labor (1)	Incites coughing and sneezing; contains stimulant	4, 7
12	*Nepeta cataria*	Catnip	Tea for baby colic; for hives (1)	Contains volatile oils and tannin; for colic; a carminative	4, 5, 15
13	*Pinus elliotti*	Pine tree	Resin for boils and to stop bleeding; tea for chill & fever, earache (3)	For hemorrhaging; an antiseptic	4, 15
14	*Phytolacca americana*	Poke plant	Root in whiskey for arthritis; for ground itch (3)	Plasma cell proliferation; an Indian poultice for skin disorders; contains phytolaccine	4, 5, 6, 7, 11, 12 14, 15, 19
15	*Prunus serotina*	Wild cherry	Gum syrup for coughs, colds or croup (4)	Contains amygdalin; a sedative cough syrup	6, 10, 12, 13, 15, 16
16	*Pteridium aquilinum*	Fern	Fern tea plus tallow for burns (1)	Contains tannin and oils	5, 12
17	*Pterocaulon undulatum*	Black root	Root tea causes abortion (2)	Used by Indians as powerful purgative	6
18	*Quercus falcuta*	Red oak	For ulcers, colitis, piles; a poultice (6)	Contains tannic acid; for diarrhea and GI disturbances	5, 6, 16, 21
19	*Quercus margaretta*	Post oak	Bark tea for colitis (1)	For GI disturbances; contains tannin	6
20	*Rhus copallina*	Sumac	Root tea poultice in erysipelas (1)	An Indian poultice; an antiseptic	4, 6, 7, 13
21	*Serracenia minor*	Trumpet plant	Root tea or boiled for indigestion, diarrhea or vomiting; for cough (5)	Used by Indians for smallpox; contains an alkaloid savacennine; for dyspepsia	6
22	*Sassafras albidum*	Sassafras	Root or bark tea for tonic; for thrush; for measles (3)	Used by Indians as tonic; for syphilis	4, 5, 6, 11, 15 18, 22
23	*Stillungia sylvatica*	Queen's delight	Root tea to purify the blood; for V.D. (1)	Blood purifier; an emetic or purgative	4, 5, 6, 7, 11, 15
24	*Trilisa odoratissima*	Deer tongue	Leaf pillow for asthma (1)	A diaphoretic; used as tobacco flavoring; a demulcent	5, 7, 15
25	*Verbascum thapsus*	Mullein	Leaf tea for foot swelling (1)	A demulcent; a mucilage contains volatile oils	4, 5, 15, 17
26	*Vinca major*	Periwinkle	Tea for a bood tonic (2)	Contains alkaloids; for diabetes; contains vincristine and vinblastine	5, 8, 20
27	*Xanthoxylan clava-hercules*	Prickly ash	Root tea for venereal disease (1)	Contains berberine; for syphilis; a diaphoretic	4, 5, 6, 7, 11, 15
28	*Xanthium americanum*	Cocklebur	Green burr in warm milk for snakebite (1)	Contains alkaloids and glucosides	5, 16
29	*Zea mays*	Corn	Corn shuck tea for measles; for fever; corn silk cigarettes for sore throat (3)	Contains alkaloids; for fever	5, 11

*Number in parentheses refers to number of informants

Table 3.—Other Folk Medicines Reported.

	Scientific Name	Common Name	Usefulness According to County Residents*
1	*Asimina speciosa*	Gopher apple	Root tea for rheumatism (1)
2	*Brassica juncea*	Mustard	Leaf poultice to chest for pneumonia (1)
3	*Brassica depressa*	Turnip	Wilted leaf as poultice for cuts (1)
4	*Cnidosculus stimulosus*	Sting nettle	Root tea is sexual stimulant (1)
5	*Eriogonum tomentosum*	Rabbit tobacco	Pillow of dried leaves for asthma (1)
6	*Gnaphalium purpream*	Life Everlasting	Pillow of dried leaves for asthma
7	*Ipomoea batatas*	Sweet potato	Raw potato stops diarrhea; raw slice over conjunctivitis (2)
8	*Lageneria vulgaris*	Gourd	Wrap feet in green leaves for ground itch (1)
9	*Opuntia lata*	Prickly pear	Beaten and used as a poultice for cuts or boils (2)
10	*Paspalum difforme*	Blue grass	Tea for colitis
11	*Prunus persica*	Peach	Chop heart of seed, fry with lard for earache (1)

*Number in parentheses refers to number of informants reporting the remedy.

nal impressions (e.g., a pregnant woman should never touch her face because this may cause a birthmarked baby). In the same county a Bohemian speech group[25] holds analogous beliefs regarding home remedies and attitudes toward chiropractors and doctors. Similar phenomena are found elsewhere in the interface between Western and indigenous medicine. For example, in Latin American cultures, often the curandero (local healer) is believed to "cure the cause" and Western medicine is believed to treat the symptom. It is likely that most rural areas have somewhat similar beliefs and self-treatment practices, as many small town practitioners know. It is important that both rural and urban physicians be aware of these since health problems and associated beliefs transport with the individuals who comprise the continuing rural-to-urban migration.

Folk remedies may still be in use, although the usual patient rarely admits this information to his doctor; some of these may very well have distinct relations to some of the patient's symptoms. (Who can forget lipoid pneumonitis secondary to the use of chronic mineral oil intake for constipation?) Patent medicines are used commonly[1] and the type used may largely depend on the current television advertisements; here, too, the patient may be hesitant in admitting to the use of these medications unless specifically asked. It should also be pointed out that often the physician is held in perhaps even less esteem than the nurse, pharmacist or chiropractor in rural communities. Reflection on these findings is certainly in order for all of us.

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▶ Dr. Barrow, Division of Cardiology, University of Florida College of Medicine, Gainesville 32601.

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addendum

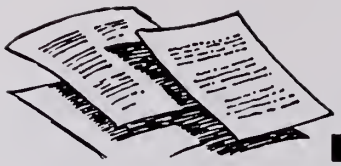
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INDICATIONS	DOSAGE (1st Day)	ADDITIONAL REGIMEN	COMMENTS
Pinworm disease	Two doses of 1 tablet/50 lb	Repeat 7 days later	This regimen is designed to reduce the risk of reinfection. However, if not practical, repeat the regimen the next day.
Threadworm,* large roundworm,* hookworm,* and whipworm* disease	Two doses of 1 tablet/50 lb	Repeat the next day	Alternatively, a single dose of 2 tablets/50 lb may be given. However, a higher incidence of side effects should be expected.
Creeping eruption	Two doses of 1 tablet/50 lb	Repeat the next day	If active lesions are still present 2 days after completing this regimen, a second course is recommended.
Symptoms of trichinosis* during the invasive phase of the disease	Two doses of 1 tablet/50 lb	Repeat for 2 to 4 successive days	The optimal dosage for the treatment of trichinosis has not been established.

The recommended maximal daily dosage is 3 g (6 tablets).

*Clinical experience with thiabendazole for treatment of each of these conditions in children weighing less than 30 lb has been limited.



Letters

Editor's Note: On July 11, 1971, one of Jacksonville's most admired and approachable psychiatrists fell while sawing off a large limb of a tree in front of his new office and injured his back. He immediately realized that he was unable to move. A subsequent examination revealed irreversible damage to the spinal cord and news soon spread around our community that Lindsey Campbell was paralyzed from the waist down and would be so for the rest of his life. Along with remarks that in his specialty, he soon shou'd be able to return to p-actice, as we pictured him sounding like Lionel Barrymore's Dr. Gillespie, making rounds with young Dr. Kildares, went the fear of how would he react psychologically. Would he really be able to go back to practice or would he become bitter, depressed and develop despair and self-pity about the many complications of a transected cord. His friends all over the State will be glad to know that he is on the rapid road to recovery, is actively planning to make his experience so full of meaning that he will be able to use it in treating patients with similar conditions, and will be in his office next month. Best wishes, Lindsey, for many years of helpful service in your profession.

Dear Editor:

A belated expression of appreciation to all my colleagues and friends who have been so attentive to my needs during my disability.

It seems that I am progressing slowly but, like the turtle in the race, with some younger rabbits around me who progress faster. At least I'm sticking my neck out, taking one step at a time in my rehabilitation. Hopefully, I will come out of this much wiser in regards to how I may prevent the complications that bring those younger hares back into the Spinal Cord Injury Service (SCIS) ward here with decubiti, bladder and renal infections, ectopic calcifications, contractures, etc., which too often develop from neglecting self-care as I am learning it here.

At this point, my spastic neurogenic bladder, following an electroincision of the bladder neck three weeks ago, is not behaving as expected and I am back on the intermittent catheterizations (which we are taught to do ourselves) to reduce the residual urine. I am also learning self-hypnosis to help me cope with some of the weirdest "sensory disturbances" in my perineum, lower extremities and lower back. After four hypnosis sessions I am beginning to see some benefits. Paraplegics are not supposed to have pain below the level of their lesions but most of my para friends here have all experienced them. Very little is documented in the medical literature concerning these discomforts which are referred to as "cauda equinal pains," "phantom sensations," "autonomic dysreflexias," etc. As Henry Heyl, editor of the Journal of Neurosurgery, who suffered an injury leaving him paraplegic in 1951, pointed out in an article in 1956 (J. Neurosurgery 13:184-186, 1956), much needs to be learned about these peculiar sensory disturbances. I am planning to write him for subsequent personal experiences of his own and obtain any further pertinent information as part of my preparations in writing my own paper on the subject.

I am in contact with a local Korean M.D. who tells me of her experiences with acupuncture (don't scoff it away) as a procedure of proven benefit in relieving such discomforts in the Orient (Dimond, E. G.: J.A.M.A. 218(10): 1558-1563, Dec. 6, 1971).

As of now, I am anticipating having accomplished the best possible benefits in my course of treatment and rehabilitation in this hospital by sometime in June and hope to be heading home shortly thereafter. My son, David, is tentatively planning to drive out and we hope to tour the country enroute home as part of my own "psychosocial rehabilitation." I expect to continue treatment and rehabilitation under my physicians there as I explore suitable approaches to returning to work.

If there be anything fortunate about my having become paraplegic, it has given me cause to consider carefully how best I can resume my professional work in perhaps an even more meaningful way than prior to my injury. I am serious about the need for study, research and development of therapeutic measures for the relief of my own and other paraplegics. It may be that I can present a paper covering my efforts to a FMA specialty section on Neurology and Psychiatry, which I perceive out here coming closer and closer together.

My deepest gratitude to all of you.

Lindsey D. Campbell, M.D.
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5205 San Jose Boulevard
Jacksonville, Florida 32207

The annual meeting of the Paralyzed Veterans of America (PVA) is being held at the Americana Hotel, Bal Harbour, in July.

Dear Editor:

I wish to point out several inaccuracies in an article on federal drug regulations appearing in the February, 1972 issue of the Journal of the Florida Medical Association.

1. Ritalin, amphetamines (Dexedrine, Benzedrine, etc.), methamphetamines (Desoxyn, Methedrine, Syndrox, all dosage forms) and Preludin are Schedule II substances and not Schedule III substances as listed in the article. Schedule II substances also include the pure narcotics.

2. Librium and Valium are not included in the Controlled Substances Act. The article lists them as being included in Schedule IV.

Below is a brief listing of narcotics included in the Controlled Substances Act. A complete listing can be found in the 21st Code of Federal Regulations, Chapter II, Section 300.0 to the chapter end.

Schedule II

Alphaprodine (Nisentil)
Anileridine (Leritine)
Cocaine
Codeine
Dihydrocodeine
Dihydrocodeinone (Hydrocodone-Dicodid, Mercodinone)
Dihydrohydroxycodeinone (Oxycodone-Percodan)
Dihydrohydroxymorphinone (Oxymorphone-Numorphan)
Dihydromorphinone (Dilaudid)
Ethylmorphine (Dionin)
Levorphanol (Levo-Dormoran)
Methadone (Dolophine)
Morphine
Opium*
Pantopon (Concentrated Opium)
Pethidine (Meperidine-Demerol)
Phenazocine (Prinadol)
Piminodine (Alvodine)

*The isoquinoline alkaloids of opium are not controlled under this law; they include: Papaverine, Noscapine, Cotarnine and Narceine.

Schedules III-V

Paregoric is included in Schedule III
Lomotil is included in Schedule V
Mixtures containing Codeine, Dihydrocodeine, Dihydrocodeinone, Ethylmorphine and Morphine are included in Schedules III-V. These prescriptions must include the prescriber's BNDD number.

As a student pharmacist, I have received many prescriptions for controlled substances that did not contain all the required information. The time taken to obtain the missing information often inconveniences the patient. If the physician is aware of the drugs that are included in the Controlled Substances Act and the information required on a prescription written for these drugs, this inconvenience to the patient can be eliminated.

Following is the information required on a prescription order for a controlled substance:

1. Name, address and BNDD registration number of prescribing practitioner
2. Full name and address of patient
3. Date of issue
4. Name and quantity of drug
5. Signature of prescribing practitioner in ink or indelible pencil
6. Prescription must be written in ink, indelible pencil or typewritten

Schedule II drugs must have a written prescription from the prescriber to be dispensed: an oral prescription is allowed for Schedule III-V drugs.

Miss Carol Norsworthy
Fourth Year Pharmacy Student
University of Florida
College of Pharmacy
Gainesville

Editor's Note: On page 36 of the February issue of the Journal, an article entitled "New Federal Drugs and Regulations Now in Effect" was taken from a FDA brochure sent to us. Changes were subsequently made, however, by the FDA after the manufacturers successfully appealed, requesting that certain drugs such as Valium and Librium were not subject to abuse as other drugs in the Controlled Substances Act. The proposed regulation to place these two drugs on the list was published but the final order was never issued and they were never subject to the controlled substances regulations. Schedule I substances are not available to the general public by prescription. Certain practitioners might be allowed to conduct "research and instructional activities with controlled substances listed in Schedule I" which requires a separate, independent registration. For more information call Agent Anthony Acri (BNDD Miami) (305) 350-4441.

Effective May 1, 1972, only Bureau of Narcotics and Dangerous Drugs official order forms will be valid for transactions involving Schedule I and II controlled substances. Any practitioner may obtain the new forms by forwarding the old type IRS order form requisition (IRS Form 679) to the BNDD Registration Branch, P.O. Box 28083, Central Station, Washington, D.C. 20005.

The registrant's complete, nine character BNDD registration number must be shown on the form in order that it may be processed. IRS Form 679 will not be honored as a valid requisition for official order forms after April 30, 1972. Any registrant who does not now have an IRS requisition, and who desires the new order forms, is required to complete form BND 222D and forward it to the Registration Branch or any BNDD Regional Office.

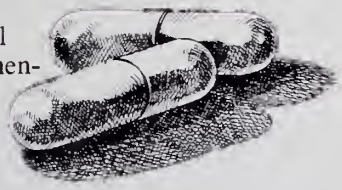
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Before prescribing, please consult complete product information, summary of which follows:

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Editorials

The Goal of Medical Education

When sometime this month in the warm summer sun, having survived the frustration of long years of formal education, groups of students robed as medieval scholars, recite a legendary oath, one wonders who will become the idealistic, selfless healer developing professional competency, compassion, integrity and honesty; or who, seduced by the newly begotten opportunity to bill for what he formerly had done-for-free, will transform the doctor-patient relation into a producer-consumer transaction, reducing the consultation room to a bargain counter. Beset by the visages of saints and charlatans, barbers and midwives, military surgeons and monks, ghosts of their curious heritage, and despite the aseptic pretentions of their education, these young physicians will, at some time, consciously or unconsciously, play one of these ancestral roles for contemporary medicine as surely as its practice is based upon a transaction between two people—the physician and his patient.

Today, not only is this product being critically analyzed but the method of how the handiwork has been fashioned is being questioned and debated in pedigogical circles where current innovations in medical education are proposed by some and deplored by others. Evidence of the result of the old system is the present generation of practicing M.D.'s. Does today's doctor, educated by twenty years of formal schooling, bedside discussions and standard patterns of hospital house officership, really manifest the lofty qualities to which we all aspire? More and more, our patients, the critical public, are saying "No!"

Four thousand five hundred more physicians by 1976 are being called for to improve the nation's health care and meet health manpower needs. While there are other ways in which the number of physicians can be increased without shortening the length of medical education and a probable loss in quality, well documented studies have suggested that the quality of observed medical care correlates with the length of formal education. This, however, is not confirmed by European educators who have discovered that a reduction by one-half in elementary schooling does not result in a corresponding decrease in student achievement; rather, it is based on background factors such as the socioeconomic structure of their family life, number of pupils per teacher, parental education and types of community. Precipitated, perhaps, by factors encountered prior to beginning school, this ferment brewing in education is found at every level, the direction having turned away from achievement and toward mass leveling; promoting students regardless of performance, destroying any incentive in striving to engender pride in one's own work. Admitting students to college without further selection makes required remedial services needed to make up for the deficiencies of the high school education. Such unprepared students continue as perpetual residents, frustrated failures, drop-outs and hard core activitists, uncontributing to the enhancement of their educational institutions. Should preparation for a life in the practice of medicine parallel this philosophy in response to public and political pressures? So coerced, medicine, long considered a learned profession, would regress into a guild of medical technicians. Physicians have, since the time of Hippocrates, been highly educated scholars and statesmen, among the world's foremost authors, well versed in history, language, philosophy and with some understanding of past cultures. This background in humanities provides an understanding of many aspects of life and the ability to communicate with a wide variety of patients. Early ingrained habits of reading and studying continue in the life patterns of many physicians. Concurrently, with science having produced more advances in medicine in the last fifty years than in our previous history, training programs in preparation for

medical careers were lengthened, sciences competing with the humanities for space in the education of the prospective physician. But with the new educational innovations, more often will a student complete medical school with limited training in the humanities. If the profession of medicine is to continue as a leading force in our civilization and physicians continue to contribute to the cultural as well as the technical forces of our civilization, we must become more concerned with the finished product and less with the duration of his training. Undoubtedly, students acquire knowledge, maturity and technical skill at varying speeds requiring varying periods of schooling. Would not the ideal physician be the product of a mature, conscientious student, stimulated and inspired by a dedicated teacher to proceed through courses of the arts and sciences at as rapid a speed as he can comprehend, preparing for a lifetime of learning to assimilate the knowledge needed to be the kind of physician to provide continuing comprehensive medical care to all our citizens.

Contrary to the apparent present popular campus dictum of today "to turn freedom into license, privilege into pride, prayer into begging, our churches into sects" and our profession into a trade, may the practicing physician of today so live and so act as to inspire students to think of their education not as something to shorten, condense or abridge but rather as an uninterrupted sequence of day-to-day experiences in the life of a total man, a compassionate physician and a leader in public health affairs.

C.M.C.

Involvement and Relevance

In professional and political organizations, as well as in the pulpit, the leadership professes a desire to *involve* the membership more directly in the operation of the organization. Such pious thought leads to exhortations from the rostrum to the attendees in the audience to attend more regularly, speak their minds, join committee activity, and, in general be *involved*. Leadership usually believes this to be a proper activity until a minority (or a majority) of the membership differs strongly with leadership on one or more issues and threatens to markedly change direction, emphasis, or operation of the organization.

Medical organizations may suffer from active participation of only a few in the running of the organization and the disinterest or disillusionment of the many. The few who take an active interest in the affairs of the organization feel unjustly criticized for their individual effort, and especially in being called a ruling clique. The many who offer only tacit support of the organization and will not give of their time and personal effort feel estranged from decision and policy-making.

Human nature being what it is, it is doubtful that patterns of meetings will change markedly. We can therefore continue to expect a relative minority of the membership to attend meetings and to offer their time and effort in the running of the organization. What might be offered to the remaining membership is the opportunity to voice their opinion in an effective manner through mail ballots in which important questions are discussed, opinions sought, and where the effect of such plebiscites would be felt at the decision-making level of the organization. Such a radical scheme is in operation in certain professional engineering societies, and has seemed to offer yet an additional channel for communication. Measures similar to this may be taken at the Annual Meeting, where poll-taking and vote-counting often can be utilized by a sincere administering body in the development of pertinent and desirable programs.

The question which has defied solution for many generations has to do with that portion of the congregation which sits not in front of the minister, but by numbers alone forms an important and often majority group within the congregation.

Eugene L. Nagel, M.D.
Miami



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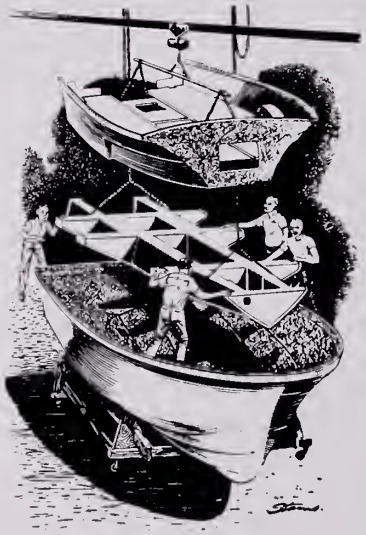
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William J. Dean, M.D.
96th FMA President

William J. Dean of St. Petersburg, whose special interest is internal medicine, began serving as President of the Florida Medical Association Sunday, May 7, as the 98th annual meeting ended at Hollywood-by-the-Sea.

Chosen as President-Elect last year, Dr. Dean's name was placed in nomination by St. Petersburg colleague, Dr. Jack A. MaCris. There followed addresses of endorsement by Dr. John A. Rush of Jacksonville representing Duval County Medical Society; Dr. William W. Trice of Tampa, Hillsborough County Medical Association; Dr. W. Dean Steward of Orlando, Orange County Medical Society, and Dr. W. Merrill Wilhoit of Pensacola, Escambia County Medical Society.

After the election Dr. Dean commented: "Thank you very much. I will do my best to carry out the wishes of this body." Thus accepting the highest honor his fellow Florida physicians could bestow he assumed responsibilities which had been passed down from Dr. Abel S. Baldwin in 1874.

In the Association's near-century of existence, Dr. Dean is the third Pinellas County physician to serve as its President. Dr. Francis H. Langley held the office in 1956 and Dr. Orion O. Feaster in 1936.

A decade ago Dr. Dean served as chairman of a reference committee at the Association's annual meeting. The previous year, 1961, he had been elected secretary of the Pinellas County Medical Society. While serving that Society as president in 1966 he was elected Vice President of the Association and since that time has been a member of the Board of Governors.

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Hi Doc:

I want to tell you about my friend, William J. Dean, M.D., who has been installed as our new FMA President.

Bill was born in Atlanta, (formerly Marthasville) Georgia in 1924, to Aura and Vivian Dean. The Dean family moved to St. Petersburg, Florida in 1935, where Bill attended the local public schools. In 1942 he graduated from the St. Petersburg Senior High School, having been chosen President of the senior class. This same year the State of Florida recognized Bill Dean as an outstanding leader and student when he was elected President of the State National Honor Society.

He returned to Atlanta where he earned his B.S. and M.D. degrees at Emory University and was honored by election to the O.D.K. leadership fraternity. While at Emory he served as President of the S.A.E. social fraternity and the Phi Chi medical fraternity.

Dr. Dean's achievements to this point (1972) are too numerous to narrate, so I'll try to list them.

1. Bill interned and served his residency in Internal Medicine at Atlanta's Grady Memorial Hospital. He served a fellowship in cardiology at the Emory University Hospital.
2. Served the United States Army as a Major in the Medical Corp. Spent 1950 and 1951 in Korea and was later Chief of Cardiology at Fort Carson, Colorado.
3. Began the private practice of Internal Medicine in St. Petersburg in 1954. Is a staff member of the Bayfront Medical Center where he served on the Medical Council, the Credentials Committee and as Chief of Medicine. As a staff member of St. Anthony's Hospital he is currently Chief of Medicine and a member of the Executive Committee.
4. Bill has helped build and served the Pinellas County Medical Society as Secretary, President and Judicial Council member. He has served Florida Physicians and the FMA as Vice-President, FMA Board of Governors, FMA Relative Values Committee member, member of the Medical Advisory Committee to the Florida Industrial Commission, and Vice-President of the Florida Medical Foundation. He has also served as a member of the Florida Blue Shield Board of Directors for 9 years.
5. Besides being a Diplomate of the American Board of Internal Medicine, Bill belongs to the A.M.A., Florida Society of Internal Medicine, American Society of Internal Medicine and is a Fellow of the American College of Physicians.
6. The Dean family are members of St. Lukes United Methodist Church where Bill is currently Chairman of the Committee on Pastor—Parish Relations, having served as Chairman of the Official Board and the Board of Trustees.
7. Bill is a charter member of the St. Petersburg Sertoma Club.

It is easy to see that we have chosen wisely in selecting William J. Dean, M.D., to head the Florida Medical Association. The wisdom of this decision is re-inforced when one considers Bill's greatest achievement, the wooing and winning of Polly Grant. Bill and Polly were married in 1947. Their union has been blessed with three fine children. Bryson 21, and Julie 19, currently students at the University of Florida, and David, a knowledgable mechanic at the age of 16.

Edward L. Cole Jr., M.D.
St. Petersburg

Highlights, FMA Annual Meeting

The 98th Annual Meeting of the Florida Medical Association, after three long sessions of the House of Delegates over a period of four days at the Diplomat Hotel in Hollywood, was adjourned by its new president, Bill Dean, in his first official performance. Four days earlier, the meetings had been opened by Charles Donegan who performed admirably as speaker of the House, instructing delegates and maintaining order during the reports of five reference committees. Controversial issues were decided; Dr. Hurt's portrait was presented to Mrs. Hurt by Dr. Dean and a personal gavel and the president's certificate was given to Dr. Dean by Dr. Hurt. This certificate contained the names of the 95 preceding presidents of FMA including that of the incoming president.

On the preceding days, delegates sat through two sessions of the House and through the proceedings of the reference committees whose members and chairmen deserve a special vote of thanks for the long hours that they gave listening to the remarks of every physician who wished to revamp the FMA, make a resolution, amend one, or just inform the committee so as to influence its decisions. The reference committee chairmen, Drs. Irving M. Essrig, Allyn B. Giffin, Richard C. Clay, Louis C. Murray and Thad Moseley, using tact and understanding in conducting the business before their committees, displayed oratorical finesse in presenting their reports before the House. Recommendations before the committees were sometimes dull, sometimes grandiose and sometimes idealistic but they all represented the thoughts of some medical society who had decided that the time had come for their resolution to become a matter of policy and so had developed the campaigning zeal to put this resolution before the House of Delegates. On the second day of the meeting, the Blue Shield Board of Directors met, well attended by participating physicians. Conducted by Robert Zellner, chairman of the Board, James L. Borland Jr. and Andri S. Capi, were the two new members elected to the Board. An address citing the California Blue Shield Corporation was enlightening and informative.

The next day at the general session, Dr. Floyd Hurt presented Governor Reubin Askew whose address challenged the Association to provide available comprehensive medical care for all citizens.

John J. Cheleden received the Certificate of Merit; State Senator David C. Lane the Certificate of Appreciation while Henry L. Harrell was given the A. H. Robins Award for "outstanding community service by a physician."

One highlight of the meeting was the FMA auxiliary FLAMPAC luncheon. This included the singing by a high school group of talented, attractive students. While the music seemed rather strange at first, as one listened intently, familiar words could be heard. The music changed to a martial air, and one could detect the words "I am proud to be an American" and "His truth is marching on." When the music swung into this familiar tune, the audience was so overwhelmed that they gave the group a standing ovation. There was no generation gap at the close of this meeting. Guest speaker U.S. Representative Wilbur D. Mills assured us that there would be no national health insurance legislation this year but that we should work to develop a plan to make it unnecessary for Washington to form a federal health care delivery system. He further stated that he will oppose a piecemeal approach to NHI legislation, is opposed to free standing insurance to meet the cost of catastrophic illness and the adoption of the Professional Standards Review Organization as proposed by Senator Bennett of Utah.

Everybody attended the President's reception where Walter Winchester and the editor were seen wearing narrow ties, vintage 1970. Gene Peek wore a dark business suit and Sam Day wore . . . you'll have to ask your delegate what she, I mean he, wore. In the receiving line, Floyd and Verona Hurt accepted congratulations on a job well done while Bill and Polly Dean were given best wishes for a successful year.

Throughout the four days, past presidents William Roberts, Walter Jones and Jere Annis were seen welcoming old friends, while Bob

Zellner, Jack Cleveland and George Palmer took part in reference committee discussions. Dean Steward, Sam Day and Henry Babers showed floor tactic agility in their appearances before the House of Delegates. Bringing back memories of bygone years were the familiar faces of Joe Stewart, John Milton and Leo Wachtel.

Passed by the House were resolutions to establish 30 hours of continuing medical education as a minimal requirement for maintenance of Association membership to become effective January 1974; to develop a form of Association membership for medical students enrolled in Florida medical schools; to continue to participate actively in and guide FRMP; to alter the composition of the Council on Specialty Medicine to include a single elected representative from each specialty organization recognized by the FMA for a one year term, subject to reelection, to be given the privilege of the floor of the House but without a vote; that suspension of payments for assigned Medicare cases be reinstituted and no payments suspended until all cases had been reviewed by the State Peer Review Committee; that all Medicare directives be published 30 days before going into effect and mailed to physicians and hospitals. The House also laid down specific requirements for peer review, and that the present composition of a State Peer Review Committee does reflect true peer review. Charlie Tate of Miami received an ovation when he answered a charge that the House was cutting off debate on the dual fee schedule by explaining that reference committee V had sat until late afternoon to hear every protagonist on this controversial issue. This resolution was defeated. Adopted against the advice of the reference committee and the chairman of the Board of Blue Shield, was a resolution that Blue Shield phase out all contracts providing essentially less than 50% prepaid coverage. Also, against the reference committee recommendations, was adopted a resolution recommending that Florida Blue Shield use as one of their criteria, the FMA 1971 Relative Value Study. Blue Shield of Florida, Inc. was assured of the support of its participating physicians and county medical societies and individual physicians were urged to actively support, strengthen and maintain Blue Shield and its programs. Adopted was a resolution endorsing a state wide health data system. Let pass was a resolution that the FMA endorse the need for legislative changes to establish a fair mechanism to exempt physicians from serving on juries in those instances where health care of the patient may be compromised. The voice vote on a resolution to form a physician's union was initially so close that a count had to be taken. Recommended was a revision of the current legislation to provide proper funding of all aspects of medical care for the indigent and that the FMA Board of Governors undertake an indepth study of the specific deficiences of the Florida Medicaid program. Approved was a report of the Council on Allied Professions and Vocations as being concerned with the current trend to shortening medical education curriculum, the lessening amount of clinic exposure and required humanities.

At the conclusion of the third meeting of the House of Delegates, in the election of officers, there was no opposition to Joe Von Thron of Cocoa Beach who was elected unanimously as President-Elect; John Fletcher from Tampa was elected Vice President; Franklin Evans from Coral Gables became Speaker of the House, and Louis Murray of Orlando, Vice-Speaker. Jim Walker from Jacksonville was re-elected Secretary-Treasurer. The AMA delegates and alternates—Drs. Francis Holland, Frank Coleman, Sam Day, Jack Cleveland and Richard Connar were re-elected. To fill the vacancy of an alternate delegate, the House elevated its speaker, Charles Donegan.

All in all, it was for the most part, interesting and informative. It again demonstrated the democratic principles upon which our Association is organized, that vested interests are seldom served, that the smallest county society can submit a resolution, that any local society can present its views, selfish, humanitarian or altruistic, and that any delegate can obtain the floor and before the entire House of Delegates state his opinions or plead his cause.

To our elected officials, all members of the hard working reference committees and their chairmen, Harold Parham as well as our full time staff, and to each member of the House of Delegates, should go a vote of thanks from all the physicians in Florida.

C.M.C.

Analysis of Florida Abortion Law Reform (CS for SB 284)

This law provides that a physician licensed under Chapter 458 or 459, Florida Statutes, or a physician practicing medicine or osteopathy in the employ of the United States or this State, may terminate a pregnancy in an approved facility provided he certifies in writing that:

(1) To a reasonable degree of medical certainty the continuation of the pregnancy would substantially impair the life or health of the female; or
(2) There is substantial risk that the continuation of the pregnancy would result in the birth of a child with a serious physical or mental defect; or
(3) There is reasonable cause to believe that the pregnancy resulted from rape or incest.

An "approved facility" means a hospital licensed by the State and accredited by the Joint Commission on Accreditation of Hospitals or approved by the American Osteopathic Hospital Association or a medical facility that is licensed by the Division of Health and operates pursuant to specific rules and regulations adopted with regard to abortions which, as a minimum, shall include requirements for regular evaluation and review procedures.

A written request by the woman is required, along with the written consent of her husband (if married) unless the husband is voluntarily living apart from the wife. If unmarried and under eighteen years of age, the written consent of parents or legal guardian is required; however, when there is a reasonable degree of medical certainty that the continuation of the pregnancy would threaten the life of the pregnant woman, the pregnancy may be terminated without said written consent if the medical opinion is corroborated by at least one additional physician.

Records are required to be kept to include the date the procedure was performed, the reason for same and the period of gestation at the time the procedure was performed. A copy of these reports shall be filed with the Department of Health and Rehabilitative Services and shall be confidential and privileged information.

Penalties authorized under the bill are as follows:

(1) If the unlawful termination of the pregnancy does not result in the death of the mother:
 (a) The penalty is that of a third degree felony which provides for imprisonment in the state penitentiary not to exceed five (5) years, or a fine not to exceed $5,000, or both.
 (b) If the defendent is a subsequent felony offender and the unlawful act is within five (5) years of the commission of his previous offense, or within five (5) years of his release from prison as a result of said offense, the penalty is imprisonment not exceeding ten (10) years.
 (c) If the unlawful termination of pregnancy resulted in the death of the mother, the penalty is that of a second degree felony, which is imprisonment not exceeding fifteen (15) years or a fine not exceeding $10,000, or both.
 (d) In cases resulting in the death of the mother, and a subsequent offense is involved as described above, the imprisonment may be up to thirty (30) years.
(2) In cases where the defendent has violated Section 3 of the act requiring the securing of written requests, or Section 4 of the act involving reporting procedures, the penalty is that of a misdemeanor in the first degree authorizing imprisonment in the county jail not exceeding one (1) year or a fine not exceeding $1,000, or both.

The law makes it clear that no violation is involved in the performance of a procedure which terminates a pregnancy in order to deliver a live child.

Some men spend so much time trying to make a killing that they forget to make a living.

Activities of FMA'S Ad Hoc Committee on Drug Abuse

Robert P. Johnson, M.D.

The House of Delegates of the Florida Medical Association, at its meeting in May of 1970, created an Ad Hoc Committee on Drug Abuse. In doing so, it was acting on recommendation of the Association's Committee on Child Health.

From its very inception this has been a unique committee of the FMA because of its general structure. It is an interdisciplinary group of professional men and women who have a vital interest in this tremendous problem of drug abuse in our State, both personally and through the organizations and professions they represent.

Since the first meeting in Jacksonville on November 17, 1970, its membership has increased from 15 to 20. Three representatives of state government agencies serve as consultants. What originally started as a one-day meeting every five or six weeks is now a two-day meeting with subcommittee meetings taking the first day and the full Committee the following day.

The Committee is composed of representatives of the FMA and its Woman's Auxiliary, Florida Pharmaceutical Association, State Department of Education, State Board of Regents, Bureau of Comprehensive Health Planning, State Division of Health, Florida Bar, Juvenile Court Judges, Law Enforcement, Florida Education Association, Florida Pediatric Society, State Board of Medical Examiners and the Clergy.

Our consultants represent the Drug Abuse Program of the Department of Health and Rehabilitative Services, the Governor's Office and the Attorney General's Office. These representatives give freely of their time and in many cases personal expense to add their input to our deliberations and I am sincerely gratified to report that the meetings are always well attended even though they are held in various parts of the State. I cannot speak highly enough of their diligent and conscientious service.

The Committee is advisory in nature and offers its expertise to any agency which desires this assistance; on occasion, we give it even though we have not been specifically requested to do so when, in our opinion, the need is sufficient to warrant investigation.

One of the first agencies to ask for our assistance was the State Department of Education, which requested that we formulate a set of guidelines to be used by school personnel in elementary and secondary schools concerned with drug use and abuse. These guidelines were drawn up by a Subcommittee on Education after many months of work and hearings with law enforcement officials and educators. They have now been accepted by the Department of Education and have been circulated to all county school systems and are being almost unanimously accepted and implemented.

We have been active in the field of State Legislation, both in an advisory capacity to the Legislature and the institution of recommendations for subsequently passed legislation. We feel this to be an extremely important function of the Committee.

We have done extensive investigation into several areas where there would appear to be a need for a re-assessment and perhaps controls. First of all, we support unanimously the recommendation of the AMA and the Board of Governors of the FMA that physicians be urged to limit their use of amphetamines and other stimulant drugs to specific, well recognized, medical indications. This is a very generalized recommendation but I believe the intent is self-explanatory. We strongly recommend that some control be placed on the dispensing of disposable needles and syringes. Metropolitan Dade County has an ordinance forbidding sale without a prescription. We would favor such legislation but would accept a lesser control which would accomplish the same purpose. We can no longer continue to place this paraphernalia in the hands of young people indiscriminately.

Presented at the 14th Annual Conference of County Medical Society Presidents and Secretaries in Orlando, January 29, 1972.

Dr. Johnson, of Tallahassee, is Chairman of the FMA Ad Hoc Committee on Drug Abuse.

We also must urge all physicians to insure non-usability of these items when disposed of in the office refuse. The Committee still remains in favor of a triplicate narcotic prescription plan for Florida but is continuing its investigation of the plan before beginning any further thrust in this direction.

There is a need, in our opinion, for expanded laboratory facilities within the Division of Health for analysis of urine specimens particularly for Methadone Clinics in the State. These clinics have specific requirements from the Bureau of Narcotics and Dangerous Drugs for spot checking of urine on a weekly basis and at present existing funds for this purpose are limited. This possibility is currently being explored with the Division. We supported legislation in the past session of the Legislature relative to a change in the marijuana laws in Florida. On the basis of existing evidence, we do not now see any basis for a further liberalization of this law. We favor the establishment within Florida of a uniform controlled substance act and we have been working with the Legislature on this matter.

We have acted as the intermediary on numerous problems existing between the government and private segments of the drug abuse problem in Florida and are continuing to do so.

For the past several months we have been very concerned with the problem of youthful drug offenders and facilities and methods for their treatment. A Subcommittee on Youthful Drug Offenders was appointed and it proceeded through its chairman, Mrs. Arnold Spanjers, to survey the governors of the other 49 states as to what programs they had, how they were funded, and their shortcomings. The response was tremendous as 46 governors replied to our inquiry and voluminous amounts of helpful material were received.

Next it was felt that we should survey the Juvenile Court Judges in Florida to determine their feelings and needs in this area. We received replies from 60 per cent representing a good statewide distribution, and almost unanimously they felt that facilities available to them were inadequate. This, then, identified the need, and work is continuing very vigorously to attempt to correct this situation. The Subcommittee is working very actively with the Division of Youth Services of the Department of Health and Rehabilitative Services, and we anticipate much improvement in the area of drug education and rehabilitation to update an already excellent program within the Division of Management of Youthful Offenders.

For approximately one year now the Committee has been working very actively on a project that we feel to be of utmost importance. Through the help of the New York State Department of Health, a grant from the Drug Abuse Program of the Department of Health and Rehabilitative Services, and the work of the members of the Committee, you have received in the mail a Desk Reference on Drug Abuse. We believe this to be one of the most important pieces of information that a physician can have available to him. The manual covers diagnosis and emergency treatment of drug overdoses, a section on the legal responsibilities of the physician in treating cases of drug abuse, and a section listing the names, addresses, structural make-up, and the directors of referral facilities in all areas. There is also a section on laboratories that will analyze urine specimens for dangerous drugs and an up-to-date bibliography for those who would care to look further into specific drug problems. Lastly, but by no means least, is a dictionary of drug culture language. This has been a major undertaking on our part but we believe that the rewards to be gained by its use make our efforts worthwhile. We sincerely hope that all of the physicians in Florida will keep this reference handy in their offices and refer to it freely.

In the very near future the Committee is going to be asked to provide its services and experience to the Attorney General's office for a very challenging project which will have a far-reaching effect on drug education in Florida and the nation. Final details are being formulated and an announcement will probably be made in April. This will be a giant step forward and will very likely be the Committee's greatest undertaking to date.

The Committee has always been concerned about the role of the private physician in dealing with the drug problem in his community. More and more youngsters and distraught parents are looking to him for guidance and help. To quote a portion of an editorial appearing in the January 11, 1971, issue of the American Medical News, "A more realistic approach to the problem is needed, and the medical profession must lead the way. Because of his education and his standing in the community the physician is the ideal individual to educate those who would use drugs about the dangers, and to educate the public about ways to meet the problem." Bertram S. Brown, M.D., Director of the National Institute

of Mental Health, has stated that "Physicians must be deeply knowledgeable and effective advocates for upgrading care in order to treat drug addicts successfully." We feel so strongly about the need of the medical profession to become more involved in the drug problem that we have established a Subcommittee on Physician Involvement. You will receive in the mail a survey to fill out and return to us, so that we may attempt to find out why more doctors are not involved in the program, and to ascertain in what way we can assist you in becoming more knowledgeable in volunteering your services in the field of drug treatment and education. A recent survey of 5,000 high school students reveals some very interesting results. I think perhaps for the purpose of this discussion one question has the greatest significance. The question is asked if you had or have a drug problem and wish assistance, to whom would you go. Number one on the list was a former drug addict. Number two on the list was the personal physician and at the end of a long list of others, including clergymen, attorneys, etc., was a drug counselor. I think the results of this survey speak for themselves. It has been my experience personally and the experience of many others that when you go to talk to young people about the drug problem they listen to a physician with more interest and respect than to anyone else. The logical place for the parents of a young person who is abusing drugs to turn is their family physician.

You must be able to meet this challenge. And a challenge it truly is. I recently addressed a conference in Jacksonville and heard a former young drug user make this statement: "Unless you are involved in trying to help stop the problem you must consider yourself part of the problem."

The Board of Governors of this Association has requested that all county medical societies establish ad hoc committees on drug abuse. If this has not yet been accomplished in your society, let me urge you to do this without delay. I tell you now that we are being criticized for not taking a more active role in this problem and this attitude must be changed. Appoint physicians to your committee who are genuinely interested in the problem and will be willing to work with the community leaders when asked. Believe me when I say they are very much in need of and desirous of your services.

It is time for the medical profession in Florida to stand up and be counted, for this is not a problem that is going to disappear by itself. The fact that Miami is now the largest single port of entry of illegal drugs in the United States and the fact that we now conservatively estimate 15,000 hard core heroin addicts in the southeast Florida area are reasons enough for us to become involved.

The profession has never failed in the past to come to the aid of the public during a period of crisis. The *drug crisis* is upon us and no one can ever convince me that this profession will not rise to meet the challenge once again.

▶ Dr. Johnson, 1330 Miccosukee Road, Tallahassee 32303.

IMPORTANT NOTICE—WORKMEN'S COMPENSATION

"Effective June 15, 1972, Medical-Surgical Fee Schedules will be increased:

Follow-up Hospital Visit—$8.00.

Conversion factor for Surgery, Medicine and Anesthesiology—$6.50.
Anesthesia time units ten minutes.

Conversion factor for Radiology and Pathology—$6.00
Physical therapy treatments by the doctor or his aide
1 modality —$ 8.00
2 or more modalities—$10.00

Physical therapy by registered physical therapist will be—Usual and Customary—whether in a private doctor's office or in a physical therapist's office.

All of these changes should be applied to the Workmen's Compensation Schedule of 1971, which was based largely on FMA Relative Value Study of 1968. (We were unable to get Tallahassee to adopt the 1971 RVS, because it hadn't even been written at the time of the Fee Schedule hearing.)"

Joseph G. Matthews, M.D., Chairman
FMA Ad Hoc Committee on
Workmen's Compensation

COMMITTEE OF 17

The Florida Medical Association's Advisory Committee to Blue Shield and Fiscal Intermediaries

Routine Newborn Care

Blue Shield is offering coverage on an optional basis and at extra cost, for routine newborn care in its new policies. This is an important and monumental first and is in keeping with the wishes of the House of Delegates of the Florida Medical Association. For years Blue Shield has covered the sick newborn babies and has pioneered the way in this area of insurance coverage so that now other companies have begun to carry this form of insurance.

The newborn child has gone through a rigorous and traumatic experience during the moment of delivery. This has consisted of a difficult passage to a new environment, a loss of maternal blood supply and oxygen. Frequently the newborn is in severe shock and does require considerable judgment on the part of the attending physician to aid this new life during its first few days. The attitude that the newborn is as healthy and as normal as any normal adult is an archaic thought and belongs with those that talk about the blue plate special or the little black Ford.

Mortality rates have dropped from forty nine per thousand to nineteen per thousand newborns in the past thirty years. This change has come because of numerous things, but primarily because of the expertise of the caring physician and his many new and more exacting modalities of care and treatment.

Blue Shield has been cognizant of these changes in the care of the newborn and has recognized that to sustain this fragile life it does require more well trained doctors. The training time, the knowledge and the judgment of those in this field demands that they be reimbursed for this care.

High infant mortality rates have been used as an indicator of the poor quality of American medicine, while in reality this level was and still is a measure of the failure of those planners to correct the appalling conditions of the slums of America. Despite this failure, the American physician has through his care reduced the mortality rates of the newborns by thirty babies out of every thousand delivered.

It is imperative that the medical profession support this effort of Blue Shield to reimburse those physicians that work in this field. The skills and precision of those caring for the newborn is and should be just as reimbursable as any other facet of medicine.

The Florida Chapter of the American Academy of Pediatrics and the Florida Pediatric Society, Inc. recommend that each physician urge parents to subscribe to this insurance. A flyer or insert should go to all parents. An example is as follows:

Dear Parent:

My bill for the care of your baby is enclosed. Your insurance should cover this bill; if it does not, please discuss this with your insurance agent.

The early days of the life of your child are most important and should be fully insured.

Please make your feelings known to your insurance company.

The cost is so nominal that not endorsing this new type of insurance would seem absurd. The monthly rate would vary from fifteen cents to twenty three cents a month depending on the type of policy.

HENRY G. MORTON, M.D.
SARASOTA

Committee of Seventeen recommendations are not official policy until acted on by the Florida Medical Association Board of Governors.

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A highly-flavored and palatable tablet of yellow phenolphthalein, bismuth subcarbonate, bismuth subgallate in special base. Chewable. Bottles of 35 and 100. Adult Dose: Chew 1 or 2 tablets night or morning. Children (up to age 10): 1/2 tablet. A citrus drink taken with tablet will stimulate action.

PRECAUTION: Do not use when symptoms of appendicitis are present and discontinue use if skin rash appears. Dependence on laxatives can result from continued use.

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14 years ago, you had to rely on our experience.

An orally active hypoglycemic agent principally indicated in relatively mild, adult, maturity-onset, non-ketotic diabetes; also, as a supplement to insulin therapy in selected diabetic patients, it may effect a stabilization of labile diabetes and reduce insulin requirements. Certain patients intolerant to chlorpropamide therapy at usual therapeutic doses have subsequently been successfully managed with Orinase (tolbutamide).

Use in mild asymptomatic diabetic patients with abnormal glucose tolerance tests not responding to diet therapy may result in improvement of the glucose tolerance test.

Use in conjunction with phenformin is indicated when optimal control is not obtained with Orinase or phenformin alone.

Contraindications: Orinase alone is not effective in juvenile or growth-onset diabetes nor in unstable brittle diabetes where insulin therapy is required.

Orinase should not be used: when diabetes is complicated by acidosis, ketosis, or coma, or when a history of repeated bouts of acidosis or coma is obtained; in the presence of other acute complications such as fever, severe trauma, or infections; and in patients with severe renal insufficiency. Insulin is indicated in these circumstances.

Pregnancy Warning: The safety and usefulness of Orinase during pregnancy has not been established either from the standpoint of the mother or the fetus. Animal studies have demonstrated feticidal and teratogenic effects of doses of 1,000-2,500 mg./kg./day, but application to human subjects unknown. Therefore, Orinase is not recommended for the pregnant diabetic, and when administering Orinase to women of childbearing age, these facts should be borne in mind.

Precautions: Diagnostic and therapeutic measures necessary for optimal control with insulin are also necessary with Orinase. The patient on Orinase must be fully instructed: about the nature of his disease; how to prevent and detect complications; how to control his condition; not to neglect dietary restrictions, develop a careless attitude or disregard instructions relative to body weight, exercise, personal hygiene, and avoidance of infection; how to recognize and counteract impending hypoglycemia; how and when to test for glycosuria and ketonuria; how to use insulin; and to report to the physician immediately if he does not feel as well as usual.

Caution, very close observation, and careful adjustment of dose are necessary when: insulin is withdrawn during the trial period in order to avoid ketosis, acidosis, and coma; thiazide diuretics are administered which may result in aggravation of diabetic state and increased tolbutamide requirement, temporary loss of control, or even secondary failure; treating patients with impaired hepatic and/or renal function and debilitated, malnourished, or semistarved patients in order to avoid severe hypoglycemia which may require corrective therapy over several days; and treating patients with severe trauma, infection, or surgical procedures where temporary return to insulin or addition of insulin may be necessary. Response to tolbutamide is diminished in patients receiving therapy with beta blocking agents.

As some diabetics are not suitable candidates, it is essential that the physician familiarize himself with the indications, limits of application, and selection of patients for therapy.

Patients must be under continuous medical supervision, and during the initial test period should communicate with the physi-

Today you have your own.

If you're around 40 or 45, you've robably had quite a bit of clinical experience ith Orinase.

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On the one hand, you know that diet d weight control are the initial and essential undations for the management of adult-set, non-ketotic diabetes. When these easures prove satisfactory, no additional erapy is indicated. On the other hand, you ow that if these measures fail the addition of Orinase to the regimen can often help lower blood sugar. Orinase lowers blood sugar as effectively today as it did when you first prescribed it.

You also know the importance of close monitoring of the patient. Although uncommon, severe hypoglycemia may occur if the dosage is not tailored to suit his requirements.

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0.5 g. tablets

(tolbutamide, Upjohn)

ian daily, and during the first month report at least once weekly r physical examination and definitive evaluation. After a month, xaminations are recommended monthly or as indicated. Appearance of ketonuria, increase in glycosuria, unsatisfactory owering or persistent elevation of blood sugar, or failure to btain and hold clinical improvement indicate nonresponsiveness to Orinase (tolbutamide). Orinase does not obviate need for aintaining standard diet regulation. Uncooperative patients hould be considered unsuitable for therapy. Prescriptions should e refilled only on specific instruction of physician. In treating ild asymptomatic diabetic patients with abnormal glucose olerance, glucose tolerance tests should be obtained at three- six-month intervals. Orinase is not an oral insulin or a substiute for insulin and must not be used as sole therapy in juvenile iabetes or in diabetes complicated by acidosis or coma where nsulin is indispensable.

If phenformin is prescribed in combination with Orinase, appropriate package literature should be consulted.

Adverse Reactions: Severe hypoglycemia, though uncommon, ay occur and may mimic acute neurologic disorders such as erebral thrombosis. Certain factors such as hepatic and renal isease, malnutrition, advanced age, alcohol ingestion, and drenal and pituitary insufficiency may predispose to hypoglyemia and certain drugs such as insulin, phenformin, sulfonaides, oxyphenbutazone, salicylates, probenecid, monamine xidase inhibitors, phenylbutazone, bishydroxycoumarin, and henyramidol may prolong or enhance the action of Orinase and ncrease risk of hypoglycemia. Orinase long-term therapy has een reported to cause reduction in RAI uptake without producing clinical hypothyroidism or thyroid enlargement and at high doses is mildly goitrogenic in animals. Photosensitivity reactions, disulfiram-like reactions after alcohol ingestion, and false-positive tests for urine albumin have been reported.

Although usually not serious, gastrointestinal disturbances (nausea, epigastric fullness, and heartburn) and headache appear to be dose related and frequently disappear with reduction of dose or administration with meals. Allergic skin reactions (pruritus, erythema, urticaria, and morbilliform or maculopapular eruptions) are transient, usually not serious, and frequently disappear with continued administration. Orinase should be discontinued if skin reactions persist. Recent reports indicate that long-term use of Orinase has no appreciable effect on body weight.

Orinase appears to be remarkably free from gross clinical toxicity: crystalluria or other renal abnormalities have not been observed; incidence of liver dysfunction is remarkably low and jaundice has been rare and cleared readily on discontinuation of drug (carcinoma of the pancreas or other biliary obstruction should be ruled out in persistent jaundice); leukopenia; agranulocytosis; thrombocytopenia; hemolytic anemia; aplastic anemia; pancytopenia; and hepatic porphyria and porphyria cutanea tarda have been reported.

Supplied: *0.5 g. Tablets*—bottles of 50, 200, 500, and 1,000, and cartons of 100 in foil strips.

For additional product information, see your Upjohn representative or consult the package insert.

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Medical News

Clinical Center Study of Patients with Cancer of the Oral Cavity, Pharynx, Larynx, or Paranasal Sinuses

The cooperation of physicians is requested in the referral of patients with cancer of the oral cavity, pharynx, larynx, or paranasal sinuses for studies being conducted by the National Cancer Institute's Surgery Branch at the Clinical Center, National Institutes of Health, Bethesda, Maryland.

Patients selected for admission and treatment will be included in an adjuvant-therapy protocol where the treatment modalities of surgery, irradiation, and chemotherapy will be combined in such a manner as to determine the feasibility of such a therapeutic approach and its potential for decreasing the incidence of local recurrence and metastases.

Post-treatment studies are planned which will include cooperative followup between the referring physician and the National Cancer Institute.

Physicians interested in having their patients considered for admission to these studies may write or telephone: Alfred S. Ketcham, M.D., Clinical Center, Room 10-N-116, National Institutes of Health, Bethesda, Maryland 20014. Telephone: (301) 496-4164

Florida Medical Students Get Awards

Five students at the University of Florida College of Medicine received awards at a recent honors convocation. Paul Dudley White, M.D., was speaker for the ceremony.

Steven T. DeKosky, a second-year student from Cherry Hill, N.J., received the annual Alpha Omega Alpha Research Award for outstanding research. The Watson Clinic Award, presented annually to a medical student chosen by the faculty for productive effort and scientific contributions, went to Warrent E. Ross of Tampa.

Other award winners were: Richard F. Ott of Ft. Lauderdale, a third-year student, Medical Guild Award for academic excellence; Bayard D. Miller of Gainesville, Roche Award for an outstanding second-year student; and Mrs. Carol (James D.) Hollan of St. Petersburg, the Blythewood and Baker Memorial Scholarship Award for Women Medical Students.

Coronary Care Courses Listed

A series of six-day coronary care courses for physicians will be conducted at Jackson Memorial Hospital in Miami from June, 1972, through May of 1973.

Instruction has been designed to prepare the practicing physician in the management of the patient with acute myocardial infarction. Six days of comprehensive lectures and training will be given on round-the-clock scheduling. Each day will be divided into 10 hours of instruction and 14 hours on-call for problems arising in the coronary care unit.

Dates for the courses are: June 12-17, July 10-15, September 4-9, October 16-21, and December 11-16, 1972; and January 15-20, February 19-24, March 19-24, April 16-21, and May 21-26, 1973. A fee of $350 will be charged for each course.

Information may be obtained from: Louis Lemberg, M.D., Director of Tutorial Course in Coronary Care for Physicians, University of Miami School of Medicine, P. O. Box 875, Biscayne Annex, Miami, Fla. 33152.

Anesthesiologists in Florida

The ratio of anesthesiologists to general population in Florida is slightly below the national average, according to a study conducted by the American Society of Anesthesiologists.

Florida has 118 physicians practicing this specialty, and it figures out to 5.2 anesthesiologists per 100,000 persons, the ASA survey indicates. Nationally, the average is 5.5.

The specialty is most concentrated in the District of Columbia and Massachusetts, where the ratios are 15.0 and 10.0 per 100,000 people, respectively. At the other end of the list are North Dakota, North Carolina, and South Dakota, with ratios of 1.8, 1.7, and 1.1. Florida ranks 20th among the states on this basis.

DIVISION OF HEALTH

Ocean Outfalls Pose No Virus Disease Threat

Questions regarding the spread of viral diseases by Florida's recreational waters have stimulated the search for epidemiological and laboratory evidence. This is a summary of findings.

A variety of viruses, polio, coxsackie, ECHO, adeno and reo, are discharged in human feces and can be recovered readily from composite sewage samples. Undoubtedly the virus of infectious hepatitis is there also. The possibility of transmission through fecal pollution of water must be acknowledged but epidemiological evidence is lacking. Even though the clinical syndromes due to viral infections are being more accurately recognized and an increasing volume of sewage is being discharged through ocean outfalls, still there is no epidemiological evidence of human viral infections acquired from this source. We believe this negative evidence strongly indicates that the discharge of sewage through ocean outfalls provides no hazard to human health.

Untreated sewage being discharged from ocean outfalls in South Florida can contain up to 5000 enterovirus particles per liter but secondary treatment and chlorination reduces viral content to as few as 10 virus particles per liter. From the outfall to surface boil, there is a dilution of at least 100 fold and much more before it reaches recreational areas, in the unusual event there is spread toward shore. This dilution reduces to a vanishing point the possibility of man acquiring even one pathogenic virus particle from treated sewage effluent. Even less likely is the probability of consuming a dosage which might result in human disease.

Newspapers have reported a biological concentration of pathogenic viruses in fish and a hazard of spread from this source to man. It has not been noted in the scientific literature.

In 1971 the Division of Health tested for pathogenic viruses 165 specimens of a variety of fish, including shellfish, taken predominantly from known fecally polluted waters. A polio type 3 was isolated from oysters; it is known that polio and hepatitis viruses can be disseminated in shellfish. Specimens of the flesh, gills and feces of free-swimming fish yielded no viral agents.

Despite these differing reported findings, we found no laboratory or epidemiological evidence that free-swimming fish may be involved in the spread of viral agents acquired from polluted waters.

The lack of a demonstrated hazard of viral diseases from salt waters stands in contrast to earlier findings for bacterial diseases from polluted fresh waters. Over the years epidemiological evidence has related numerous outbreaks of bacterial diseases to polluted fresh waters. The occurrence of water borne outbreaks was securely established even before the infectious causes were identified. In contrast there have been no outbreaks due to exposure from salt waters.

We conclude, therefore, that there is no established risk of acquiring virus infection in Florida's offshore recreational waters. Bacterial, virological and aesthetic risks will be reduced to a vanishing point by secondary treatment of sewage and chlorination of the effluent. Rapid dilution still further diminishes risks. Pending the demonstration of other acceptable means of disposal, the use of appropriately located ocean outfalls for the discharge of treated sewage effluent warrants public health approval. Routine surveillance of recreational beach areas is indicated.

We are impressed with the need for confirmation of unusual virological findings before the dissemination of evidence. The services of the Division of Health laboratories and through them the reference diagnostic services of the Center for Disease Control in Atlanta are available to assure the accurate identification of suspect pathogens.

Data for this summary statement were collected by the staffs of the Bureaus of Laboratories, Preventable Diseases, Research, and Sanitary Engineering whose Chiefs are respectively Nathan Schneider, Ph.D.; E. Charlton Prather, M.D.; Roland B. Mitchell, Ph.D., and Sidney Berkowitz, M.S.Eng.

Wilson T. Sowder, M.D., Director
Florida Division of Health
Jacksonville

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Diagnosis—The Diagnostic Kit permits fast, accurate confirmation of suspected irritants of 50 of the most commonly encountered allergens. In addition, the Kit also contains pollens for your botanical area, a scarifier and individual scarification tips.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic urinary tract infections (primarily cystitis, pyelitis, pyelonephritis) due to susceptible organisms (usually *E. coli, Klebsiella Aerobacter, Staphylococcus aureus, Proteus mirabili* and less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies.

IMPORTANT NOTE: *In vitro* sulfonamide sensitivity tests are not always reliable. The test must be carefully coordinated with bacteriologic and clinical response. When the patient is already taking sulfonamides, follow-up cultures should have aminobenzoic acid added to the culture medium.

Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of antibacterial agents including the sulfonamides, especially in the treatment of chronic and recurrent urinary tract infections.

Free sulfonamide blood levels should be measured in patients receiving sulfonamides for serious infections since there may be wide variations with identical doses; 20 mg/100 ml should be maximum total sulfonamide level, as adverse reactions occur more frequently above this level.

Contraindications: Hypersensitivity to sulfonamides, infants less than 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis), pregnancy at term, and during the nursing period.

Warnings: Safety of sulfonamides in *pregnancy* has not been established. Sulfonamides will not eradicate group A streptococci. Deaths associated with sulfonamide administration have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts and urinalyses with careful microscopic examination should be performed frequently during sulfonamide therapy.

Precautions: Use with caution when impaired renal or hepatic function, severe allergy or bronchial asthma is present. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis (frequently a dose-related reaction) may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia, methemoglobinemia. *Allergic reactions:* Erythema multiforme (Stevens-Johnson syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia, allergic myocarditis. *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis, stomatitis. *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L.E. phenomenon have occurred with sulfonamide therapy. Sulfonamides bear certain chemical similarities to some goitrogens, diuretics and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents.

Supplied: Tablets containing 0.5 Gm sulfisoxazole.

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High urinary drug levels

Gantrisin quickly reaches peak antibacterial concentrations in the urine—usually in 2 to 3 hours. With the recommended dosage regimen, Gantrisin maintains these high urinary levels throughout therapy to combat such susceptible organisms as *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris.*

2.

Generally good tolerance

Because of Gantrisin's high solubility and rapid excretion, therapy is relatively free of adverse reactions serious enough to require discontinuance of the drug (3.1% of 1002 patients in a recent study*). Even minor reactions are comparatively infrequent, but may include nausea, headache and vomiting. For other possible undesirable reactions, and precautions, please see summary of prescribing information on opposite page.

*Koch-Weser, J., *et al.*: *Arch. Intern. Med.*, *128*:399, 1971.

For nonobstructed cystitis

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Usual adult dosage:

4 to 8 tablets *stat*

2 to 4 tablets *q.i.d.*

Is Blue Shield a Part of Medicare?

Warren W. Quillian, M.D.

The answer to the question is: NO! But let's review a few facts in an effort to clarify this common misconception. We are vitally interested in the Medicare program but only in an administrative capacity.

After the experiences of World War II, a need and public demand for adequate health care services, without great personal expense, became apparent. It is interesting that the initiative for development and organization of this type of prepayment program came from the medical profession in Florida. Enabling legislation and official approval from the state insurance commissioner were obtained, after overcoming many problems and tremendous opposition. This nonprofit medical service benefit plan, known as the Florida Medical Service Corporation, in June 1946 became Blue Shield of Florida, Inc. Confusion, misunderstandings of philosophy, dramatic growth and development have occurred. Coincident with a better informed and more cooperative medical profession came new contracts, broader coverage and merit (experience) rating for certain groups, which added impetus to progress with better acceptance by physician and the public alike. Expansion of all phases of activity has occurred through the intervening years, with improved benefits for the subscriber. One factor has never changed: our philosophy of service to subscribers and the physicians who attend them.

In December 1956, about ten and a half years after organization of Florida Blue Shield, a program was established by the Congress of the United States to pay for hospital and medical care from civilian sources for dependents of members of the uniformed services on active duty. This was originally known as Medicare! At the request of the Florida Medical Association, we in Blue Shield agreed to act as fiscal administrator only, feeling that this would be beneficial to physician and patient. Subsequently, in 1966, congressional action added to the original enactment retired military personnel and their dependents under age 65. This was called CHAMPUS (Civilian Hospital and Medical Program of the Uniformed Services), bearing the double purpose of helping physicians subject to draft and betterment of service military dependents not close to medical care. In 1967 Florida Blue Shield became the direct contracting agent with the federal government for administration of medical-surgical care benefits in this state. Previously the Florida Medical Association had been the contracting agent with Blue Shield serving as fiscal administrator.

It soon became necessary to adjust Blue Shield contracts for direct and group subscribers over age 65 in order to avoid duplication of Medicare benefits. For Medicare Part "A" hospital insurance (Blue Cross), they paid no premium. Many of them would enroll in Part "B" medical insurance. Therefore, a joint Blue Cross and Blue Shield Complementary Coverage contract was developed to supplement Medicare benefits. Primarily, complementary coverage provided payment for hospital care and other specified services to the extent that they were not covered by Medicare medical insurance (Part "B"). This, through ensuing years, required a gradual increase in premium rates. Participating physicians, delegates (or alternates) to the Florida Medical Association House of Delegates, became active members of the Plan.

Dr. Quillian is Immediate Past President of Blue Shield of Florida, Inc.

Rapid growth and the physician's dependence upon third party payments caused many changes in the Plan itself; for which Blue Shield was simply serving as administrator by contractual agreement. Rapid expansion for implementation of the Medicare program was augmented by the increased demands of our own regular underwritten business. Our membership now exceeded a million subscribers, requiring more personnel and better facilities. This necessitated a building program for even greater growth, expansion and service to the people of Florida, whom we serve.

So, while Florida Blue Shield is not a part of Medicare, the assumption of additional responsibilities in connection with our contractual agreement has increased the demands and challenges faced by our organization. We have a dedicated Board of Directors, extraordinary and very efficient executive management, with the determination to fulfill our obligations. We need the cooperative support of Florida physicians to administer successfully this phase of our effort which means so much to all our subscribers.

▶ Dr. Quillian, 140 Alhambra Circle, Coral Gables 33134.

The Fear Upon Us

Rufus K. Broadaway, M.D.

The medical profession is running scared. Some fears perhaps are justified, many others are not. One of the great fears expressed by doctors and by organized medicine is that the federal government eventually will "socialize" medical care. I believe socialization to be a bad move; furthermore, I doubt that in our time this country will take this step. In countries which have socialized their medical system, however, disease does not run rampant. Health care needs somehow are met, albeit at the expense of some freedom and reduction in income for doctors. Perhaps it is this fear which operates as strongly as the expressed fear that patients will not be cared for.

We fear the influence of "third parties" in medicine. Many regard Blue Shield as a threat because of its position as fiscal intermediary for Medicare. We fear the computerization of our medical profiles. We fear the imposition of Peer Review, even though it is accomplished through our fellow practitioners. We fear the regulation of fees through price controls. We fear the approaching requirements for continuing education and possible re-examinations and relicensure. We fear the Joint Commission on Accreditation of Hospitals, the American Hospital Association, the Association of American Medical Colleges, the power of the AMA. We even fear that DCMA and its elected officers will "sell us down the river!" We fear the press and the health planners and we fear the effect that the voice of the medical consumer might have upon us and our image.

It seems strange that the wealthiest, most influential profession in our nation should be fearful, a profession which is largely respected and which has done an admirable job in moulding the health care of this country. We have, in choosing medicine as a career, dedicated ourselves to its goals and purposes. If we do this job as we know it should be done, we need fear no critic. As an example, two of our recent legislative efforts have been made against chiropractic—surely a negligible influence in this community—and against having doctors called for jury duty (despite the evidence that FMA could not find one incident of a doctor's having been forced to jury duty). Surely our vision is larger than this. There are great constructive themes involving the care of our fellow citizens. By addressing ourselves to them, we shall maintain the respect of others, as well as that of ourselves.

Dr. Broadaway is Editor of the Dade County Medical Association Bulletin.

Reprinted from the Dade County Medical Association Bulletin, Miami Medicine, March 1972.

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At the quarterly meeting of the Board of Directors, on February 26, 1972 in Orlando, a letter to Dr. Granville W. Larimore, State Director of the Florida Regional Medical Program, Inc., from the Regional Medical Program Director, went in part as follows:

Dear Dr. Larimore:

This is to advise you of the results of the Florida Regional Medical Program's grant application which was submitted for consideration during the January/February 1972 Review Cycle and reflects the comments and recommendations of RMPS staff, the site visitors, and the Review Committee as concurred in by the National Advisory Council and represents a culmination of the review process as it relates to your region.

A summary of the action taken is as follows: Approval of the triennial application with recommended levels of $1,927,706 for the fourth year [72-73], $1,987,250 for the fifth year, and $1,964,775 for the sixth year. Included in this recommendation was approval of the Developmental Component and partial support of Project #43—*A Comprehensive Program for Renal Disease Control for Florida*. . . .the Florida Regional Medical Program has made substantial progress during the past two years and has developed a well organized and viable program. Considering the many problems which faced the Region two years ago, Council was pleased to learn that the FRMP has realistically and forthrightly come to grips with these internal problems and has successfully solved most of them. The Council's observations, recommendations, and advice are presented in terms of the RMPS Review Criteria; i.e., Performance, Process and Program Proposal The reviewers noted that while improved quality of health care is still being stressed, the FRMP is also emphasizing the availability and accessibility of health care as evidenced in a number of the ongoing and proposed activities and that your planning process does take into account the health care deficiencies and needs of the state and relates well to the overall program priorities and planned activities. The Council noted that both provider and consumer groups were represented in the setting of goals and priorities and believed that a sound and enduring process has been established which will insure that the Florida RMP will remain relevant to both national and local health care goals. . . .

The fact that the entire State of Florida has been drawn together as a viable and cohesive Region was considered a major accomplishment. The reviewers were pleased to learn that relationships and responsibilities between the grantee agency and the Regional Advisory Group have been delineated and are effectively working. They were equally impressed with the total reorganization of FRMP which has resulted in the establishment of a more effective RAG, and the formation of an executive committee and subcommittees which apparently are coming to grips with the real health care problems in the Region. The fact that you have been able to establish sound and effective planning and evaluation mechanisms, a good local review process, and implementation of an efficient management system are certainly outstanding accomplishments.

The Council was aware that most of the projects in the past were medical school projects, uncontrolled and even unaudited by the central core staff, but was pleased to learn that as the Region became organized the planning and evaluation committee began to look at these ongoing projects, auditing and measuring their effectiveness in relation to the program's goals and objectives. With regard to the current operational projects as well as those proposed, Council believed they all seem suitably related to the program goals and priorities. Some, such as the Children's Cancer project, the Community Health Guides project and others relating to community health centers, the Council believes have had a great and beneficial impact in specific areas. The reviewers were favorably impressed with the activities conducted under the Health Guides project, and as mentioned to you at the time of the site visit, advises the Region to strongly consider replication of this activity to other densely populated areas within the Region. . . .

The Council noted that the FRMP policy of requiring projects to provide continuation support after termination of FRMP funding has been quite successful. This is evidenced by the fact that seven of the currently funded projects which are

in the final year of FRMP support will continue their activities through non-RMP sources. . . .

[These are:

Community Multitest Health Screening Center, Richard Gordon, M.D., University of Florida

Computerized EKG Processing Center, Lamar Crevasse, M.D., University of Florida

Intensive Inservice Education for Physicians—University of Florida, Emanuel Suter, M.D., University of Florida

Computerization of Coronary Care Units, Gordon Ira Jr., M.D., University Hospital of Jacksonville

A Program for Cardiovascular Screening and EKG Analysis, M. E. Groover Jr., M.D., Division of Health

Remote Supervision of Paramedical Personnel Via Telemetry, Eugene L. Nagel, M.D., University of Miami

Florida Coronary Care Nurses Training Program, Louis Lemberg, M.D., Florida Heart Association]

The reviewers strongly urge the Region to strengthen its efforts toward the recruitment of minorities for employment in core staff positions and to include more active involvement of minority representatives on the RAG to support the commitment to the achievement of equal employment opportunity and equal representation in the RMPs that represent the health interest of all the people the regions serve. . . .

The Council was favorably impressed with the strength and leadership of the Regional Advisory Group which is effectively carrying out its responsibilities and is clearly in control of policy formation and has been definitely exercising these powers. Council was pleased to learn that the membership has been broadened to insure adequate representation but believed that more active involvement of minority representatives should be encouraged. They were also pleased to note that with the reorganization of the program and the definition of the policy role of the RAG, the grantee agency served principally as the fiscal agent and guarantor of the program. The grantee organization is still obviously powerful, but Council was made aware that it exercises this power legitimately through consultation with the RAG and the Coordinator. Council was satisfied to learn that the problems previously existing in this area seem to be solved.

It was quite evident to the Council that the FRMP has successfully developed good relationships with the various voluntary health agencies, the CHP (A) agency, the State Health offices, the Hospital Association, the Nursing Association, the state and local medical societies, etc., and these agencies do participate in and strongly support the program. The Council noted that while the FRMP has developed good working relationships with the various agencies, there is no indication that anyone has co-opted the program for its private gain. . . .

We were pleased to hear of your concern relative to the development of programs designed to improve the delivery of health care to migrant laborers and the rural poor in Florida. We wish to encourage you in identification of such needs and the implementation of programs to meet these needs. . . . Although evaluation in the past has not been one of the Region's stronger points, the Council was made aware that this is in the process of changing. Council was impressed to learn that with the help of Dr. Herman Hilleboe, the Region has developed what appears to be a sound evaluation process for both program and project activities. . . .

Council believed that FRMP has been able to develop local processes which would result in sound local decisions and concluded that the Region has now reached a level of maturity to prudently administer the use of a Developmental Component Award.

Council agreed with staff in recommending that Project #43—*A Renal Disease Program for Florida,* be partially funded at the level of $375.000 for its first year; $313,500 for the second year, and $251,625 for the third year. It was Council's opinion that the Region should support fulltime transplantation surgeons at the two ongoing transplant centers. Council believed that there is a necessity for a fulltime commitment to organ procurement as well as the development of a competent transplantation team. In addition, the Region should make attempts to work with the Florida Kidney Board and the Florida Kidney Foundation to improve the opportunities for home dialysis training for those patients in whom transplantation is not indicated. . . . The Region is encouraged to continue to support only one tissue typing center in order to prevent unnecessary duplication throughout the Region. . . .

HAROLD MARGULIES, M.D., DIRECTOR
REGIONAL MEDICAL PROGRAM

MEETINGS

Approved by FMA Committee on Continuing Education

JULY

10-15 Course of Instruction in Coronary Care for the Practicing Physician, Jackson Memorial Hospital, Miami. For information: Louis Lemberg, M.D., U. of Miami School of Medicine, Box 875, Biscayne Annex, Miami 33152.

SEPTEMBER

4- 9 Course of Instruction in Coronary Care for the Practicing Physician, Jackson Memorial Hospital, Miami. For information: Louis Lemberg, M.D., U. of Miami School of Medicine, Box 875, Biscayne Annex, Miami 33152.

OCTOBER

16-21 Course of Instruction in Coronary Care for the Practicing Physician, Jackson Memorial Hospital, Miami. For information: Louis Lemberg, M.D., U. of Miami School of Medicine, Box 875, Biscayne Annex, Miami 33152.

DECEMBER

8-10 "The Spinal Cord Injured Patient," from the Department of Orthopaedics and Rehabilitation, University of Miami School of Medicine, Americana Hotel, Miami Beach. For information: Augusto Sarmiento, M.D., Box 875, Biscayne Annex, Miami 33152.

11-13 "The Advance in Orthotics—1972," from the Department of Orthopaedics and Rehabilitation, University of Miami School of Medicine, Americana Hotel, Miami Beach. For information: Augusto Sarmiento, M.D., Box 875, Biscayne Annex, Miami 33152.

11-16 Course of Instruction in Coronary Care for the Practicing Physician, Jackson Memorial Hospital, Miami. For information: Louis Lemberg, M.D., U. of Miami School of Medicine, Box 875, Biscayne Annex, Miami 33152.

Florida State Board of Medical Examiners:
Jan. 28-30, 1973, Tampa

For information: Mrs. Marjoriann Keebler, Administrative Assistant, Florida State Board of Medical Examiners, 2717 E. Oakland Pk. Blvd., Fort Lauderdale, Fla. 33306.

National and Regional Meetings Held in Florida

NOVEMBER

2- 4 International Conference on Trichinellosis, Sheraton-Four Ambassadors Hotel, Miami. Sec.: W. C. Campbell, Ph.D., Merck Institute, Rahway, N. J. 07065.

2- 6 Association of American Medical Colleges, Fontainebleau Hotel, Miami Beach. Pres.: John A. D. Cooper, M.D., 1 Dupont Circle, Washington, D. C. 20036.

6-10 American Society of Tropical Medicine and Hygiene, Deauville Hotel, Miami Beach. Sec.-Treas.: George R. Healy, Ph.D., P.O. Box 15208, Emory University Branch, Atlanta, Ga. 30333.

19-22 Pan American Medical Association, Deauville Hotel, Miami Beach. Dir. Gen.: Joseph J. Eller, M.D., 745 5th Avenue, New York 10022.

DECEMBER

1- 2 American College of Chemosurgery, Balmoral Hotel, Miami, Sec.-Treas.: Richard S. Moraites, M.D., 7721 Montgomery Rd., Cincinnati, Ohio 45236.

2- 7 American Academy of Dermatology, Americana Hotel, Miami Beach. Sec.-Treas.: Frederick A. J. Kingery, M.D., 2250 Northwest Flanders Street, Portland, Oregon 97210.

3- 6 American Society of Hematology, Diplomat Hotel, Miami Beach. Sec.: Steven Robinson, M.D., Beth Israel Hospital, 330 Brookline Avenue, Boston 02215.

4- 6 Southern Surgical Association, Boca Raton Hotel, Boca Raton, Sec.: David C. Sabiston Jr., M.D., Duke University Medical Center, Durham, N.C. 27710.

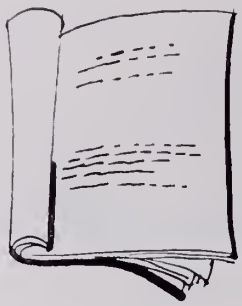
1973

MAY

21-24 American College of Obstetricians and Gynecologists, Americana Hotel, Miami Beach. Dir.: Michael Newton, M.D., 79 West Monroe Street, Chicago 60603.

JUNE

11-15 Society of Nuclear Medicine, Americana Hotel, Miami Beach. Exec. Dir.: Mrs. Margaret Glos, 211 East 43rd Street, New York 10017.



Reprinted from .

Editor's Soliloquy

Us Gents

With the advent of spring—that resurrective season of blooming crocuses at the margins of melting snowdrifts, the first sturdy robin listening out an unwary angleworm, the invisible chattering grosbeaks busily building their nests before introducing themselves to the feeder, and the first golfer skirting the spongy, forbidden greens—we are again honoring our Fifty-Club members: those gentlemen of rare wisdom; a distinguishing asset generally belied by the deceptive tranquility of their demeanor.

True, these eminent seniors are being superseded and perhaps superannuated by a younger, vociferous group of hot-bloods: hirsutely adorned individuals with visionary and hence unvindicated ideals; out to conquer the world by turning it inside out and upside down to shake it free of what they regard as a hoary mould of ancient, dusty cobwebs, so that fresh air and sunlight can permeate and sterilize it.

Your Fifty-Club members are experientially well-qualified but hesitant to proffer unasked advice, for too often their valuable counsel is ignored, occasionally even scorned. So, regretfully, they accept the dictum that most of history is about to be repeated because it will not be listened to.* These gentlemen have endured, if not willingly tolerated, most of the socio-political-economic evils that have perennially corrupted their social milieu, and they have neither taste nor inclination for perpetuating them. Besides, they have seen other dichotomies in life than the generation gap. Perhaps to them dichotomies represent nothing more than the inevitable swing of the proverbial pendulum, without which the clock would stop! Furthermore, because the terminal pages in life's book are almost all turned over for them, these men are content to be tender with the last few leaves, lest they be brittle and crumble in the process like the pages of an ancient heirloom volume that the inexorable hand of Time has weathered, too fragile for rough handling.

I was about to examine a litigant who claimed that his aching joints, his failing vision, his impaired hearing, and his wobbly knees were all ascribable to a minor accident in which he had bruised his thumb. As a preliminary to the major examination which was to follow, we, in our mutual seniority, eyed each other; he through his high-diopter post-cataract lenses, and I through my trifocals. I hadn't yet noted his chronologic age of 72 as recorded by my office nurse, but mentally speculated that he might be 90; however, as our reciprocally appraising glances met I perceived a shrewd twinkle in his eye, and I had to respect the accuracy of his evaluation, while abnegating my own, as he sagely observed: "Us gents ain't getting any younger, is we?"

Carl O. Rice, M.D., Editor Emeritus
Minnesota Medicine

*Santayana: "Those who fail to listen to history are bound to repeat it."

Reprinted from Minnesota Medicine, May 1971.

A Modern Psychiatric Hospital . . .



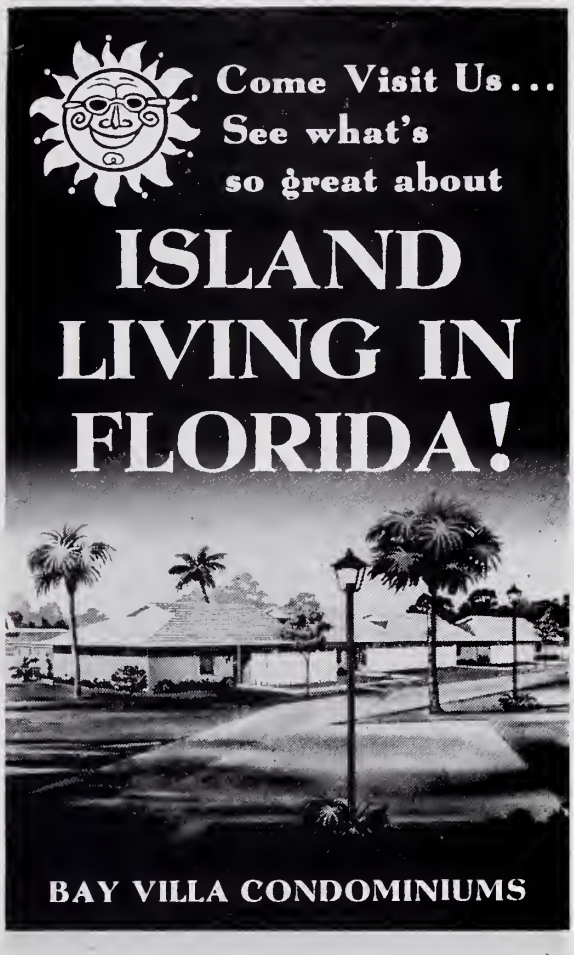
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CLINICAL BRIEFS

Macroamylasemia

Steven Bernstein, M.D.

In 1964, Wilding, Cooke and Nicholson described a patient with malabsorption, jejunal abnormalities, hypoalbuminemia, edema and persistently elevated levels of serum amylase with reduced renal clearance of amylase.[1] Studies of her serum, urine and salivary secretions over eight years demonstrated that there were high levels of circulating amylase associated with an abnormal "gamma-macroglobulin" in the 19S-7S range. Autopsy revealed essentially normal pancreas and kidneys, although cholelithiasis was found; examination of the small bowel confirmed the presence of adult celiac disease. No connection between the abnormal amylase-globulin complex and the remainder of the clinical picture could be made.

Three years later Berk et al described three patients with complexing of amylase to an abnormal globulin and coined the term "macroamylasemia" to describe the serum abnormality.[2] In these patients also elevated serum amylase values contrasted with low renal excretion of amylase. However, two of the patients were alcoholics and both had elevated serum lipase as well; malabsorption was not present and small bowel x-rays were normal in the two patients so studied.

Investigation revealed that sera from these individuals contained two classes of amylase: type I seemed to correspond to free normal amylase while type II was an amylase-globulin complex. Polyacrylamide-gel electrophoresis of the type I amylase showed it to exhibit a single peak in contrast to the double peak of normal amylase. This single peak did not exactly correspond to either the pancreatic or parotid peaks of normal serum. Further analysis of the type II material could not conclusively demonstrate binding of the amylase to the 7S globulin nor could the hypothesis be disproven that the macroamylase was a macromolecular aggregate of normal amylase. It was found that the macroamylase of each patient was distinct from the others; this heterogeneity could not be explained. The authors could not attribute any clinical symptoms to the macroamylasemia.

The idea that an autoimmune mechanism underlies macroamylasemia received support from Levitt and Cooperband[3] who described an elderly, nonalcoholic lady with life-long diarrhea, hyperamylasemia and depressed renal amylase clearance whose macroamylasemia was due to binding of amylase to an 11S immunoglobulin A. Malabsorption of fat and xylose was found; peroral biopsy demonstrated clubbed jejunal villi, cuboidal, vacuolated epithelial elements and infiltration of the lamina propria with mononuclear cells, primarily plasmacytes. The authors showed that the macroamylase was not a macromolecular aggregate but rather the association of amylase with an 11S-IgA having the characteristics of an antigen-antibody immunoglobulin complex. This complex was larger than that found by Berk et al whose patients had a 7S-amylase moiety.

A clue to the reason for this disparity was furnished when Levitt et al reported on four additional patients with macroamylasemia.[4] Three of them had an amylase-7S complex, no malabsorption and no evidence of antigen-antibody interaction; they were similar to the patients studied by Berk et al. The fourth patient, however, suffered from prolonged diarrhea, malabsorption of xylose and fat and had subtotal villous atrophy on peroral jejunal biopsy; her macroamylase was an amylase-11S complex. She did not have elevated IgA immunoglobulins but was otherwise quite similar to the first case reported by Levitt et al and to the original case of Wilding and associates. On the basis

of this data the authors suggest that there are two syndromes of macroamylasemia, one an asymptomatic coupling of amylase with 7S globulin and the other manifesting malabsorption, subtotal villous atrophy, complexing of amylase with an 11S IgA and possible autoimmune etiology.

Despite the prediction of Dr. Berk[2] only ten cases of macroamylasemia have appeared in the English literature in the seven years since its description. Of these there are complete data for only five,[1-3] preliminary data for four,[4] and passing mention only for the tenth.[5] The relationship of macroamylasemia to clinical disease, although suggestive in three cases, remains insecure.

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5. Levitt, M. D.; Rapoport, M., and Cooperband, S. R.: Renal Clearance of Amylase in Renal Insufficiency, Acute Pancreatitis and Macroamylasemia, Ann. Int. Med. 71:919, 1969.

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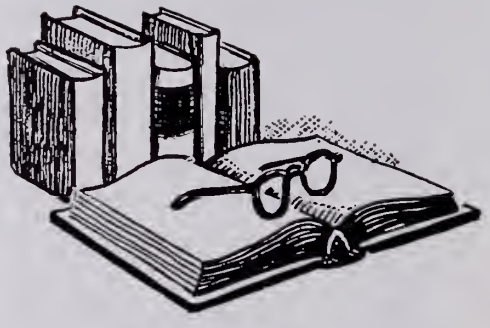


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Book Review

Shands' Handbook of Orthopaedic Surgery by R. Beverly Raney Sr., M.D. and H. Robert Brashear Jr., M.D. Pp. 543. 419 Illustrations. Price $15.50. St. Louis, The C. V. Mosby Company, 1971.

Thirty-five years have passed since Dr. Alfred R. Shands wrote the first edition of this clear and comprehensive textbook. Now in its 8th edition, co-authored by his associate, Dr. R. Beverly Raney Sr., it remains an excellent source of basic fundamentals on orthopedic surgery. The book retains the precise and down-to-earth literary style commenced and maintained through the years by Dr. Shands.

Notwithstanding its comprehensive presentation of orthopedic principles, the book provides the reader, whether he is a student, medical practitioner, resident or physiotherapist, easy access to an excellent simplified reference. (This book has been used as an orthopedic primer in some medical colleges here and abroad.)

This book's quality and usability is augmented by 419 illustrations consisting of x-rays, diagrams, case photographs, and pathology slides and simulates the demands of clinical interpretation. Few chapters are noteworthy in the sense that they deal with common medical problems in everyday practice, such as, "Affections of the Low Back;" "Chronic Arthritis;" "Neuromuscular Affections," and "Infections of Bone and Joints." Some of the improvements in this edition were made to keep up with changing medical knowhow and theory in orthopedics. This is particularly emphasized in 79 pages of bibliography with 1,466 titles mostly from recent journals and newly published texts, most of which are easily retrievable.

This textbook is concise and well-organized. Its simple literary style makes it an easy, pleasant book to read. It is an ideal book to have in a medical practitioner's library.

T. D. Bonzon, M.D.
Jacksonville

Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

Current Concepts in Dyslexia edited by Jack Hartstein, B.S., M.D. Pp. 212. 34 Illustrations. Price $12. St. Louis, The C. V. Mosby Company, 1971.

Approach to the Medical Care of the Sick Newborn by Sophie H. Pierog, M.D. and Angelo Ferrara, M.D. Pp. 292. 42 Illustrations. Price $11.50. St. Louis, The C. V. Mosby Company, 1971.

Biochemical Profiling in Diagnostic Medicine by Joseph A. Preston, M.D. and David B. Troxel, M.D. Pp. 51. Price $2.50 for set of five. Tarrytown, New York, Technicon Instruments Corporation, 1971.

CRC Manual of Nuclear Medicine Procedures by William H. Beierwaltes, M.D., John W. Keyes Jr., M.D. and James E. Carey, M.S. Pp. 137. Price $19.90. Cleveland, Ohio, CRC Press, 1971.

Cardiovascular Physiology, Second Edition, by Robert M. Berne, M.D. and Matthew N. Levy, M.D. Pp 265. 193 Illustrations. Price $9.25. St. Louis, The C. V. Mosby Company, 1972.

The Pediatric Nurse Practitioner by Fernando J. deCastro, M.D. and Ursula T. Rolfe, B.A., M.D. Pp. 154. Illustrated. Price $6.50. St. Louis, The C. V. Mosby Company, 1972.

A Primer of Electrocardiography by George E. Burch, M.D. and Travis Winsor, M.D. Pp. 292. 287 Illustrations. Price $7.75. Philadelphia, Lea & Febiger, 1972.

A Decade of Progress, The United States Army Medical Department 1959-1969, directed by Lt. Gen. Hal B. Jennings Jr., The Surgeon General, U. S. Army. Edited by Col. William S. Mullins, MSC, and Rose C. Engelman, Ph.D. 23 Illustrations. Pp. 214. Price $2.25. Wasbington, D. C., Office of The Surgeon General, Department of the Army, 1971.

Hematopoietic and Gastrointestinal Investigations with Radionuclides by Albert J. Gilson, M.D., William M. Smoak III, M.D. and Morton B. Weinstein, M.D. Pp. 456. Illustrated. Price $30. Springfield, Ill., Charles C. Thomas, Publisher, 1972.

Cancer Diagnosis in Children by L. D. Samuels, M.D. Pp. 131. Illustrated. Price $25. Cleveland, Ohio, CRC Press, 1972.

Advances in Forensic and Clinical Toxicology by A. S. Curry. Pp. 280. Illustrated. Price $32.50. Cleveland, Ohio, CRC Press, 1972.

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Medical Licenses Granted

The Florida State Board of Medical Examiners report that of the 976 applicants who took the examination of the Board held January 16-18, 1972 at Tampa, 567 passed and have been issued licenses to practice medicine in Florida. The names, towns, medical school and year of graduation of the successful applicants follow:

Aceituno, Andres A., Bowie, Md. (Havana, 1946)
Adler, Fred, Munster, Ind. (Buenos Aires, 1957)
Agia, Raymond T., Union City, N.J. (Ein Shams, 1962)
Agrama, Hani M., East Orange, N.J. (Ein Shams, 1958)
Ahdoot, Habibollah, Alexandria, Va. (Tehran, 1964)
Ahn, Yeon-Soong, Miami (Seoul Nat'l U., 1964)
Albacete, Rene A., Silver Spring, Md. (Havana, 1941)
Albovias, Jose C., Cuyahoqa Falls, Ohio (Manila Central U., 1957)
Almond, Thomas H., Lake Jackson, Texas (Cambridge, 1958)
Alvare-Castro, Manuel A., Tampa (Havana, 1942)
Alvarez, Rafael A., Milledgeville, Ga. (Havana, 1943)
Alvarez-Jacinto, Orestes R., Cleveland Heights, Ohio (Havana, 1951)
Alves, Angelo M., Birmingham, Ala. (Porto Faculty of Med, Portugal, 1962)
Ambrose, Paul S., Knoxville, Tenn. (Vanderbilt, 1970)
Anderson, Russell C. II, Portsmouth, N.H. (Michigan U., 1968)
Angulo, Ismael, Chicago (Nat'l U.-Bogota, 1959)
Arcacha, Miguel A. Jr., Miami (Havana, 1969)
Arce, Julio, Fort Thomas, Ky. (San Marcos U., 1956)
Arcomano, Joseph P., Huntington, N.J. (Chicago U., 1949)
Arenberg, Irving K., St. Louis (Michigan U., 1967)
Armstrong, Charles L., Winter Park (Missouri U., 1967)
Arrue, Luis R., Nashville, Tenn. (Havana, 1957)
Ashwood, Edward L., DeLand (Tennessee U., 1964)
Ausbon, William W., Columbus, Ga. (Alabama M. C., 1956)
Averbuch, Philip F., Bayside, N.Y. (Tufts, 1967)
Ayala, Luis F., Miami (Havana, 1941)
Azulay, Abraham, Colonial Springs, N.Y. (New York U., 1945)

Babcock, William S., San Antonio, Texas (Northwestern, 1966)
Baga, Nora B., St. Thomas, V. I. (Sto. Tomas, 1962)
Baggett, James C. Jr., Jacksonville (Georgia M. C., 1969)
Baldonado, Ricardo T., Brooklyn, N.Y. (Sto. Tomas, 1965)
Barnes, Clemit D., New Orleans, La. (Tulane, 1967)
Baron, George J., West Henrietta, N.Y. (Rochester U., 1941)
Barrow, William B., Fort Myers (Hahnemann, 1935)
Bayas, Charles W., Brooklyn, N.Y. (Port-Au-Prince M.S., 1953)
Bedi, Bhupinder S., Kalkaska, Mich. (Delhi U., 1966)
Bednar, Stephen, Washington, D. C. (Pennsylvania U., 1964)
Beebe, Richard J., Gainesville (Ohio State U., 1964)
Belgorod, Samuel H., New York (Columbia, 1935)
Belli, Vahit, New York (Ankara U., 1959)
Benitez, Hugo R., San Juan, P.R. (Havana, 1954)
Berkowitz, Sidney S., New York (Michigan U., 1932)
Berman, Bernard A., Brookline, Mass. (Tufts, 1948)
Bernhardt, Harvey E., Jacksonville (Louisville U., 1968)
Berrien, Stephen B., Jacksonville (St. Louis U., 1967)
Bertram, Herbert M. Jr., Vanceburg, Ky. (Louisville U., 1943)
Bertran-Escanaverino, Raul E., San Juan, P.R. (Havana, 1949)
Besman, Irvin R., Albertson, N.Y. (Temple, 1954)
Bhatti, Nazir A., Augusta, Ga. (King Edward M.C., 1957)
Bielen, Robert J., Havertown, Penn. (Pennsylvania U., 1962)
Black, Jarrett C., Arcadia (Miami U., 1962)
Bleiweiss, Irwin M., West Palm Beach (Indiana U., 1942)
Bloom, Marvin E., Arlington, Va. (Pittsburgh U., 1965)
Bogash, Morton, Philadelphia, Penn. (Pennsylvania U., 1951)
Bogen, Gregory H., Queens Village, N.Y. (Academy of Med. Lodz, Poland, 1963)
Bonessi, James V., McKeesport, Penn. (Pittsburgh U., 1956)
Bornstein, Irving D., Lexington, Mass. (Virginia U., 1956)
Bounds, Terrell B. Jr., Fort Lauderdale (Florida U., 1967)
Boylston, James A., Orlando (Duke, 1969)
Bradshaw, Harold W., Louisville, Ky. (Louisville U., 1950)
Brand, Stanley N., Fort Sheridan, Ill. (Jefferson, 1969)
Braswell, Edwin H., Pensacola (Mississippi U., 1970)
Braunstein, Paul W., Bayshore, N.Y. (Harvard, 1947)
Breaux, Charles W., New Orleans, La. (Louisiana State, 1964)
Brenner, Richard P., Orange Park (Louisville U., 1968)
Bress, Alan N., Pittsburgh, Penn. (Pittsburgh U., 1959)
Brigety, Reuben E., Jacksonville (Florida U., 1970)
Brook, David W., New York (Yale, 1961)
Brookfield, Ernest G., Toledo, Ohio (Michigan U., 1955)
Brown, Stewart D., Albany, Ind. (Indiana U., 1943)
Buchanan, Glenn C., Milton (Iowa U., 1970)
Buchman, Myron I., New York (Johns Hopkins, 1946)
Buganza, Giancarlo, Forest Hills, N.Y. (Padua U., Italy, 1953)
Busto, Rafael P., North Miami Beach (Madrid U., 1970)

Cabe, Claudio M., East Setauket, N.Y. (Sto. Tomas, 1960)
Cabrera, Landelino C., Greystone Park, N.J. (Havana, 1956)
Caceres, Jaime M., Bronx, N.Y. (Chile U., 1965)
Caceres, Juana P., Greystone Park, N.J. (Havana, 1950)
Cadice, John B., St. Louis (St. Louis U., 1959)
Calvo-Viera, Antonio, Arcadia (Madrid U., 1963)
Campbell, Barry B., San Diego, Calif. (Duke, 1967)
Carbone, Donato J., Buffalo, N.Y. (Buffalo U., 1946)
Carder, Linda G., Lake City (Southwestern U., 1961)
Castiello, Anastasio M., Coral Gables (Salamanca U., 1966)
Celestino, Vincent S., Williamsville, N.Y. (Buffalo U., 1955)
Cesiano, Lucien M., Brooklyn, N.Y. (Albert Einstein, 1969)
Chapman, Roy L., Gainesville (Tennessee U., 1969)
Charyulu, Komanduri K. N., Miami (Andhra M. C., 1951)
Chase, Stephen B., Boston, Mass. (Georgetown, 1968)
Cherry, William C. Jr., Gainesville (Emory, 1965)
Chokshi, Deenbandhu S., Miami (Grant M. C., 1962)
Christie, John P., Indianapolis, Ind. (Cincinnati U., 1965)
Chutinan, Kunnika, Bedford Heights, Ohio (Chulalongkorn M.S., 1961)
Cian, F. Frank, Garfield, N.J. (Brussels U., 1968)
Clark, Roland B., Ann Arbor, Mich. (Michigan U., 1967)
Coburn, Bry H., Fort Walton Beach (Alabama U., 1970)
Coffer, Bertram W., Orange Park (North Carolina U., 1969)
Coffman, Tommy M., Columbus, Ohio (Miami U., 1969)
Cohen, Dennis A., Gainesville (Ohio State, 1970)
Cohen, Norman N., Philadelphia, Penn. (Pennsylvania U., 1956)
Cohn, Eduardo J., North Miami (Chile U., 1968)
Cohn, Hans E. R., Miami (Vienna U., 1961)
Cohn, Herbert E., Wynnewood, Penn. (Jefferson, 1955)
Coleman, Francis W., Augusta, Ga. (Georgia M. C., 1967)
Collins, Glenn J., Jacksonville (Oklahoma U., 1935)
Conn, Jerome W., Naples (Michigan U., 1932)
Connor, Morton, New York (New York M. C., 1948)
Cook, James H., Tampa (Iowa State U., 1963)
Cooper, Ellis O., Orange Park (Louisiana State, 1967)

Cooper, Thomas P., Tampa (Indiana U., 1970)
Cooper, Philip, Gainesville (Harvard, 1934)
Corcoran, Robert L., Pittsford, N.Y. (Rochester U., 1940)
Cordell, Gerald D., Gainesville (Vanderbilt, 1970)
Corley, Thomas E., Fallbrook, Calif. (Mississippi U., 1963)
Couch, Ellis P., Fort Walton Beach (Baylor, 1968)
Courreges, Frank R., Jacksonville (Louisville State, 1967)
Crimi, Felipe, St. Louis (Nat'l U. of Cordoba, 1946)
Crosby, Robert T., Portsmouth, Va. (Louisiana State, 1965)
Curtis, Joel, Bronx, N.Y. (Chicago M. S., 1958)

D'Alonzo, C. Anthony, Wilmington, Del. (Virginia U., 1937)
Damast, Melvyn, Miami (Albert Einstein, 1967)
Dannis, Harvey L., Brooklyn, N.Y. (Chicago M. S., 1970)
David, Eriberto T., Philadelphia, Penn. (Sto. Tomas, 1965)
Davis. Lindon L., Fort Williston, L.I., N.Y. (Jefferson, 1937)
Day, Jon R., Charlottesville, Va. (Virginia U., 1969)
Dayao, Evelyn S., Daytona Beach (Philippines U., 1960)
Deangelis, Anthony M., Yonkers, N.Y. (Columbia, 1934)
Deiparine, Rolando B., Daytona Beach (Far Eastern U., 1964)
de la Pedraja, Osvaldo, Miami (Havana, 1960)
Delit, Clement, Flushing, N.Y. (West Ontario U., 1940)
Dharnidharka, Sajjan G., Miami (Grant M. C., 1968)
Diaz, Eduardo M., Elmhurst, N.Y. (Havana, 1957)
Dieguez, Miquel A., McClenny (Havana, 1928)
Djukovich, Urania G., Maywood, Ill. (Belgrade, Yugoslavia, 1956)
Dobrow, Harvey R., Annandale, Va. (S. U. N. Y., 1967)
Dodge, Ralph E. Jr., Inverness (Indiana U., 1962)
Dominguez, Amado E., Dallas, Texas (Havana, 1944)
Donn, Frederick Y., Washington, D. C. (George Wasbington, 1941)
Donnenfeld, Robert S., Dix Hills, N.Y. (New York M. C., 1953)
Douglas, William T., Hillsboro, Ill. (Northwestern, 1941)
Dowd, James F., Lantana (St. Louis U., 1937)
Duffy, Patrick A., Pensacola (St. Louis U., 1967)
Dumanis, A., Whitestone, N.Y. (Bellevue U. Hosp., 1932)
Dummit, Eldon S. Jr., Sanford, N.C. (Vanderbilt, 1959)
DuPuy, David N., Charlotte, N.C. (Miami U., 1970)
Dybner, Ruben, Elmhurst, N.Y. (Buenos Aires U., 1962)
Dziedziech, Zbigniew, Chicago (Gdansk Med. Acad., 1954)

Easterling, James F., Winter Park (Duke, 1956)
Edwards, William C., Louisville, Ky. (Yale, 1959)
Ehrenstein, Ferid I., Millington, Tenn. (Istanbul U., 1962)
Eisenstein, Morris I., Bergenfield, N.J. (St. Louis U., 1930)
Eisner, Eugene M., Detroit, Mich. (Michigan U., 1967)
Eldidy, Rene, Jacksonville (Havana, 1948)
Elser, Bernard I., Miami (Basel U., 1970)
Epstein, Herbert M., Glencoe, Ill. (Rochester U., 1949)
Epstein, Jerome D., Avon Park (Tulane, 1962)
Escobar, Nelson, Gainesville (Salamanca U., 1965)
Espiniella, Jose L., Dayton, Ohio (Havana, 1944)
Esquibel, Edward V., Glen Ellyn, Ill. (Colorado U., 1958)
Evans, Henry C. Jr., Gainesville (Vanderbilt, 1953)
Ewing, James W., St. Petersburg (Minnesota U., 1969)
Ezpeleta-Hilado, Ana M., Charleston, W. V. (Sto. Tomas, 1958)

Feierstein, Saul, Monroe, Conn. (Zurich U., 1963)
Feinzaig, Willy, San Jose, Costa Rica (Mexico U., 1958)
Feldman, David, St. Louis (Washington U., 1943)
Feldman, Emanuel, Hollis Hills, N.Y. (Tulane, 1938)
Feldman, Sidney, Brooklyn, N.Y. (Hamburg U., 1936)
Fernandez, Alfredo B., Ocean City, Md. (Havana, 1944)
Fernandez, Manuel J., Orlando (Uruguay U., 1959)
Ferrell, Roger E. Jr., Gainesville (Florida U., 1970)
Ferrer, Jorge A., Gainesville (Uruguay U., 1949)
Fiala, Josepb J., Jacksonville (J. E. Parkyne U., 1967)
Fidei, Francis G., Pensacola (Columbia, 1968)
Fine, Jack L., Pompano Beach (St. Mungos M. C., 1946)
Fitz-Randolph, Raymond H., Tampa (New York M. C., 1958)
Flagler, David G., Orange Park (Baylor, 1967)
Fleming, Martin P., Winchester, Va. (Ireland Nat'l U., 1962)
Fogel, Marvin, New York (Temple, 1960)
Foy, Robert E. Jr., Enterprise, Ala. (Alabama U., 1956)
Frankel, Jack, Great Neck, L.I., N.Y. (Tulane, 1945)
Freed, Alan A., New York (Bellevue M. S., 1932)
Fuller, James W., Tampa (Tennessee U., 1970)

Gardiner, Hugh F., Indianapolis, Ind. (Indiana U., 1969)
Garfield, Frederick M., Pompano Beach (New York M. C., 1938)
Garmendia, Jose M. Jr., Miami (Havana, 1960)
Garrigo, Luis P., Dallas, Texas (Havana, 1948)
Garruto, Anthony R., Locust, N.J. (Stritch M. S., 1960)
Geissler, William L., Shreveport, La. (Tulane, 1954)
Gelman, Stanley R., Miami (Florida U., 1968)
Gelot, Raghuvir B., Brooklyn, N.Y. (Baroda M. C., India, 1968)
Gerami, Siroos, Jacksonville (Pahlaui U., 1964)
Ginory, Alfredo A., Clinton, S. C. (Havana, 1954)
Goin, Helga, Miami (Buenos Aires U., 1964)
Giordano, Bernard P., Buffalo, N.Y. (Padua U., 1956)
Godard, Joseph E., Orlando (Vermont U., 1968)
Goldman, Gilbert S., Pittsburgh, Penn. (Washington, 1937)
Goldsmith, Joseph W. Jr., St. Paul, Minn. (Long Island M. C., 1938)
Goldstein, Henry R., New York (Kentucky U., 1968)
Gonzales, Fernando Q., Steubenville, Ohio (Sto. Tomas, 1964)
Gonzalez, Alberto, Arnold, Md. (Havana, 1944)
Gonzalez, Fredesvinda M., Miami (Santo Domingo U., 1958)
Gonzalez, Marcelino A., Coral Gables (Havana, 1940)
Goott, Bernard, St. Paul, Minn. (Witwaterstrand U., 1954)
Gordon, George B., New York (Edinburgb Royal Coll., 1937)
Gorospe, Cesar A., Warrensville Heights, Ohio (East U., 1962)
Goyle, Krishan K., Rochester, N.Y. (Punjab U., 1963)
Grabow, Harry B., Pensacola (Georgetown, 1970)
Gray, Allan W., Jacksonville (N. Carolina U., 1968)
Green, Frederick A., Jamaica, N.Y. (Basel U., 1968)
Green, Joan D., Jamaica, N.Y. (Penn. Woman's M. C., 1967)
Greenberg, Louis T., Atlanta, Ga. (Indiana U., 1961)
Gross, Gilbert L., South Euclid, Ohio (Harvard, 1949)
Gruber, Frank L., Baldwin, N.Y. (Tulane, 1956)

Hall, Douglas C., Gainesville (Florida U., 1970)
Hamilton, Oliver F. Jr., Dallas, Texas (Baylor, 1966)
Hammack, Thomas C. Jr., Pensacola (Mississippi U., 1970)
Han, Kyung M., Chicago (Catholic M. C., Korea, 1961)
Harris, Howard M., Grand Island, N.Y. (McGill U., 1955)
Hassan, Shawky A., Flint, Mich. (Cairo U., 1959)
Hausfeld, Kenneth F., Tallahassee (Cincinnati U., 1938)
Hays, Robert A., Surfside (Tufts, 1940)
Hedican, Robert E. Jr., Middleton, Wisc. (Wisconsin U., 1966)
Heflin, Thomas B., Fort Walton Beach (New York M. C., 1967)
Hegde, Belanje S., Flushing, N.Y. (Mysore U., 1965)
Hegde, Belanje V., Cleveland, Ohio (Kartatak M. C., India, 1965)
Hemphill, Robert J., Akron, Ohio (Louisville U., 1948)
Henderson, Frank W., Lake City (Jefferson, 1946)
Henson, Roger L., Pensacola (Louisville U., 1970)
Herman, Richard M., Miami (Hebrew U., Israel, 1969)
Hernandez, Rafael M., Kansas City, Mo. (Havana, 1960)
Hernandez-Vera, Gonzalo, Columbia, S. C. (Havana, 1943)
Hewson, George F., Livingston, N.J. (St. Louis U., 1933)
Hilado, Godofredo F., Charleston, W. Va. (Sto. Tomas, 1957)
Ho, Rong D., New Orleans (China M. C., 1967)
Hobgood, Shannon R., Gainesville (Florida U., 1970)
Hochman, Herbert A., Augusta, Ga. (Tulane, 1970)
Hodes, Herbert C., Orange Park (Kansas U., 1969)
Hodes, Philip J., Key Biscayne (Pennsylvania U., 1931)
Hodgson, John P., Pittsburgh, Penn. (Pittsburgh U., 1956)

Holliday, James A. Jr., Irving, Texas (Tulane, 1963)
Holowatsch, Vladimiro, Tinley Park, Ill. (Buenos Aires U., 1967)
Homsi, Rateb K., Cheboygan, Mich. (Syrian U., 1953)
Hopkins, Ralph D. Jr., Eglin AFB (Georgia M. C., 1967)
Hopper, Guy R., Westfield, N.J. (Cornell, 1943)
Horowitz, Samuel, Kew Gardens, N.Y. (New York M. C., 1933)
Horta, Ricardo G., Wilmington, N.C. (Havana, 1948)
Hough, Glenn V., Sebring (Marquette U., 1939)
Houser, Ben P., Summerland Key (Jefferson, 1934)
Houser, Cyrus G., Willingboro, N.J. (Jefferson, 1964)
Howell, James T., Tampa (Arkansas U., 1970)
Huentelman, John K., St. Petersburg (Ohio State, 1966)
Huergo, Manuel, Houston, Texas (Havana, 1937)
Hughes, William F., Westport, Conn. (Jefferson, 1948)
Humpe, James J., Nanuet, N.Y. (New York U., 1953)
Hunter, Robert C., Akron, Ohio (Maryland U., 1947)
Hurtes, Harold C., New York (Long Island M. C., 1939)
Hwang, Ing-Sei, Lakeland (Nat'l Taiwan U., 1966)
Hyatt, Henry, Atlanta, Ga. (Louvain U., 1969)

Imami, Riazul H., Indianapolis, Ind. (Nishtar M. C., Pakistan, 1956)
Ioannides, Kyriakos, Miami (Thessaloniki U., 1962)

Jensen, James W., Pompano Beach (St. Louis U., 1964)
Johnson, Donald C., Daytona Beach (Ottawa U., 1967)
Johnson, John A., Orlando (Honduras Nat'l U., 1969)
Jones, Jimmy F., Boston, Mass. (Tennessee U., 1956)
Joy, Charles A., Erie, Penn. (Buffalo U., 1946)

Kaelin, James E., Jacksonville (Louisville U., 1970)
Kahn, Steven P., Ann Arbor, Mich. (New York M. C., 1967)
Kaiser, Gerard A., Miami (Columbia, 1958)
Kaplan, Bernard I., St. Petersburg (New York U., 1935)
Kapp, John P., Hernando, Miss. (Duke, 1963)
Katz, Michael S., Miami (S. U. N. Y., Downstate, 1968)
Kaude, Juri V., Gainesville (Kiel U., 1948)
Kaufman, Sidney S., Pittsburgh, Penn. (Pittsburgh U., 1941)
Kaye, Milton, New York (Zurich U., 1935)
Kayser, Harold L., Miami (Pennsylvania U., 1954)
Keenan, Francis D. Jr., Jacksonville (Georgia M. C., 1964)
Keim, Hugo A., Tenafly, N.J. (Loyola, 1960)
Kelly, Kenneth A. Jr., Snyder, N.Y. (Buffalo U., 1950)
Kessel, Karl J., Grosse Pointe Park, Mich. (Johannes Gutenberg, 1953)
Ketabchi. Masoud. Miami (Tehran, 1965)
Kahn, Aftab A., Miami (Madras M. C., 1964)
Khodadad, Manuchehr, Evanston, Ill. (Tehran, 1954)
Kleiman, Scott G., Chicago (N. Carolina U., 1967)
Koh, Suk-Kyung, Cincinnati, Ohio (Kyung Pook U., 1957)
Kohn, Theodore, Chicago (Mexico Nat'l U., 1962)
Kotin, Edward H., Philadelphia, Penn. (Jefferson, 1930)
Krasner, Bernard, Hallandale (Tufts, 1945)
Krieg, Earl M., Jacksonville (Michigan U., 1966)
Krohn, Harold A., Lebanon, Penn. (Hahnemann, 1939)
Kunakasem, Thavorn, Somerville, N.J. (Med. Sci. U. Bangkok, 1957)
Kyker, James S., Linden, Tenn. (Tennessee U., 1967)

Lagomasino, Sira S., Peterson, N.J. (Havana, 1947)
Lamberton, William D., Erie, Penn. (Hahnemann, 1953)
Lamstein, Jacob I., Scarsdale, N.Y. (Maryland U., 1928)
Landes, Alexander V., Croton-on-Hudson, N.Y. (Long Island M. C., 1933)
Landry, Richard M., Houma, La. (Louisiana State, 1963)
Lane, James R. Jr., Miami (N. Carolina U., 1967)
Laskoff, Jeffrey M., Tampa (New York M. C., 1968)
Lau, Anthony C., Brooklyn, N.Y. (Chekiang, 1958)
Ledden, Lewis J., Trenton, N.J. (Hahnemann, 1942)
Lee, Hoi P., Brooklyn, N.Y. (Seoul Nat'l U., 1961)
Lee, Wai-Yee, Houston, Texas (Taiwan Med. Center, 1966)
Lehrfeld, Jerome W., Massapequa, N.Y. (S. U. N. Y., 1958)
Lentz, Carl W. III, Keesler AFB, Miss. (Miami U., 1970)
Leon, Hernan, New York (Bogota, Col. Nat'l U., 1966)
LeRoy, John B., Storrs, Conn. (Yale, 1950)
Leschey, William H. Jr., Cape Elizabeth, Me. (Jefferson, 1963)
Levi, Donald F., Miami (Texas U., 1962)
Levin-Epstein, Ralph H., Holyoke, Mass. (Albany M. C., 1951)
Levine, Kenneth A., Binghamton, N.Y. (Syracuse, S. U. N. Y., 1961)
Levinson, Sol, New Shrewsbury, N.J. (Albany M. C., 1949)
Levy, Jerome H., Tenafly, N.J. (S. U. N. Y., 1966)
Levy, Marshall S., Pittsburgh, Penn. (Pittsburgh U., 1953)
Levy, Roger N., New York (S. U. N. Y., 1959)
Lewis, Ralph F., Zanesville, Ohio (Ohio State, 1960)
Lichtenstein, Pavel, East Orange, N.J. (Charles U., Prague, 1968)
Lindenmayer, Ernest F., Ashtabula, Ohio (Western Reserve, 1937)
Linn, George G., Cleveland, Ohio (Western Reserve, 1938)
Lober, David A., Gainesville (S. U. N. Y., 1970)
Lofiego, Frank P., Toledo, Ohio (St. Louis U., 1953)
Loftus, Thomas A., Haworth, N.J. (Pennsylvania U., 1940)
Logan, Alonzo J., Casselberry (Georgia M. C., 1970)
Lohavichan, Choomsang, Salisbury, Md. (Siriraj M.S., 1966)
Long, Samuel E., Lake Park (George Washington, 1959)
Loza-Diaz, Francisco A., Villalba, P.R. (Havana, 1937)
Ludwig, Abraham S., Jericho, N.Y. (Chicago M.S., 1950)
Lustig, George A., New Rochelle, N.Y. (Amsterdam U., 1959)
Lyon, David C., Brooklyn, N.Y. (Oxford, 1959)

Machie, Ambrose A., Buffalo, N.Y. (Marquette, 1950)
Madry, Robert W., Gainesville (N. Carolina U., 1967)
MacGillivray, William F., E. Douglas, Mass. (Georgetown, 1947)
Magidson, James S., Setauket, N.Y. (Chicago U., 1957)
Machemer, Christine A., Miami (Albert-Ludwigs, 1959)
Meyer, Carol F., North Augusta, S. C. (Georgia M. C., 1967)
Misra, Hari K., Carnegie, Penn. (Lucknow U., 1961)
Moore, Charles R., Houston, Texas (Tennessee U., 1962)
Moreno, Leopold S., Norfolk, Va. (Buenos Aires U., 1951)
Morgan, Dolores A., Key Biscayne (Indiana U., 1968)
Moscarella, Alfred S., Tamarac (Jefferson, 1932)
Moskowitz, George R., Orlando (Basel U., 1969)
Mousavipour, Sied M., Belvidere, Ill. (Iran U., 1958)
Moyer, John A., Monroeville, Penn. (Pittsburgh U., 1954)
Murnane, Alice M., New York (Ireland Nat'l U., 1958)
Murray, Nial P., Brookline, Mass. (Ireland Nat'l U., 1954)

Nagid, Enrique G., Orlando (Madrid U., 1966)
Narula, Onkar S., Miami Beach (Amritsar Med. Col., 1961)
Neale, Arthur K., Port Washington, N.Y. (Adelaide U., 1952)
Newman, Benjamin G., Philadelphia, Penn. (Cincinnati U., 1966)

O'Brien, John J., Greenlawn, N.Y. (N. Y. M. C., 1936)
O'Connor, Joseph R., Orchard Park, N.Y. (N. Y. M. C., 1956)
Oliver, Robert K., Decatur, Ala. (Tennessee U., 1942)
Ostad, Abraham, Brooklyn, N.Y. (Tehran, 1965)
Owitz, Sidney, New Rochelle, N.Y. (Cape Town U., 1948)

Page, George E., Jacksonville (Wisconsin U., 1969)
Paisan, Julian C., Columbus, Ohio (Havana, 1957)
Parker, Herman R. II, Orange Park (N. Carolina U., 1967)
Parl, Eike L., Philadelphia, Penn. (Goettingen U., 1964)
Parry, William H., Aurora, Colo. (Indiana U., 1967)
Paryani, Bhojraj T., Jacksonville (Bombay U., 1946)
Pauly, Robert P., Winter Park (Lausanne U., 1962)
Pedroso, Frank, Richmond, Va. (Havana, 1943)
Perez, Jose, North Miami (Havana, 1948)
Perez, Manuel, Miami (Havana, 1960)
Perez-Teran, Rene M., Huntington Woods, Mich. (Havana, 1946)
Peters, Calvin R., Metairie, La. (Louisiana State, 1964)

Pickens, William S., Gainesville (Arkansas U., 1966)
Pisani, Joseph M., Brooklyn, N.Y. (Rome U., Italy, 1969)
Pizarro-Gonzalez, A. M., Cincinnati (San Simon, 1963)
Post, Lawrence A., Miami (George Washington, 1948)
Potenza, Austin D., Garden City, N.Y. (S. U. N. Y., 1954)
Powers, Harry J., Kew Gardens, N.Y. (Arkansas U., 1933)
Powner, David J., Gainesville (Florida U., 1970)
Prado-Vargas, Gervasio, Ponce, P.R. (Havana, 1939)
Pratilas, Vasilios, New York (Athens U., 1959)
Presser, Jorge I., Miami (Buenos Aires U., 1964)
Prokop, Edward K., Pittsburgh, Penn. (Florida U., 1970)
Puhl, Susan C., Gainesville (Iowa U., 1969)

Quilez, Joaquin B., Delmar, N.Y. (Barcelona U., 1959)

Rabhan, Leonard J., Savannah, Ga. (Georgia U., 1931)
Rabinowitz, Samuel J., Miami Beach (Sheffield, Eng., 1933)
Radimer, George F., Miami (Florida U., 1970)
Rajurkar, Madhusudan G., Miami (Osmania U., 1961)
Rankin, David L., San Diego, Calif. (Miami U., 1970)
Rapier, Joseph H. Jr., Jacksonville (Kentucky U., 1967)
Rau-Levine, Rosemary, West Palm Beach (Woman's M. C. of Pa., 1963)
Raymond, Bruce A., Fort Myers (Washington, 1949)
Regalado, Jacinto E., Harwick, Ga. (Havana, 1952)
Renz, Andres C., Cincinnati, Ohio (Cincinnati U., 1927)
Repass, James A., Richmond, Va. (Virginia M. C., 1965)
Retureta, Abelardo A., Miami (Havana, 1960)
Rifai, Samy F., Jacksonville (Cairo U., 1955)
Ripstein, Charles B., Great Neck, N.Y. (McGill U., 1940)
Rivera, Benjamin A., Miami Beach (Manila Central U., 1965)
Rivero, Jose M., Newark, N.J. (Havana, 1944)
Roberts, Kelly C., Orlando (Tulane, 1970)
Robles, Fernando U., Toledo, Ohio (Sto. Tomas, 1952)
Rodriguez, Fidel, Grantsville, W. Va. (Nuevo Leon U., 1956)
Rodriguez, Francisco, Buffalo, Texas (Havana, 1946)
Rodriguez-Baz, Luis I., Dayton, Ohio (Havana, 1953)
Rosenberg, Solomon J., Teaneck, N.J. (Marquette, 1944)
Rosomoff, Hubert L., Miami (Hahnemann, 1952)
Rotella, Richard C., Bronx, N.Y. (S. California U., 1960)
Roth, Trisha A. R., Miami Beach (Miami U., 1969)
Ruback, Irwin H., Oxon Hill, Md. (Louisville U., 1958)
Rubenstein, Leonard S., Pittsburgh, Penn. (Pittsburgh U., 1960)
Rubin, Emanuel J., Plainview, N.Y. (Chicago M.S., 1959)
Ryan, John J., Waltham, Mass. (Tufts, 1943)
Ruiz, Maria C., Orlando (Havana, 1947)

Sadlowski, Ronald W., Pensacola (Indiana U., 1968)
Salisbury, Brian G., Miami Beach (Pennsylvania U., 1970)
Sanderlin, Joseph M., Winter Park (St. Louis U., 1949)
Santayana, Rafael A., St. Petersburg (Havana, 1940)
Santeramo, John E., Rockville Centre, N.Y. (N. Y. M. C., 1944)
Santibanez, Sergio, Livingston, Texas (Havana, 1948)
Sarnate, Amada M., Chattanooga, Tenn. (Sto. Tomas, 1964)
Savastejko, Raisa, Chicago (Buenos Aires U., 1964)
Schneider, William J., Gainesville (Vanderbilt, 1970)
Schwartz, Harvey A., New York (S. U. N. Y., 1967)
Schwartz, Michael A., White Plains, N.Y. (Cornell, 1969)
Schwartz, Peter, Searingtown, N.Y. (S. U. N. Y., 1956)
Secor, Rollen A., Harrisburg, Penn. (Pennsylvania U., 1960)
Seidel, Horace Y. III, Easton, Penn. (Long Island M. C., 1948)
Sella, Michael, Riverdale, N.Y. (Geneva U., 1963)
Senavinin, Pravit, Barbourville, Ky. (Med. Sci. & Siriraj Hosp., 1964)
Seretan, Edward L., E. Williston, N.Y. (St. Louis U., 1940)
Shaw, Kailie R., Tampa (Cape Town U., 1966)
Sherman, David H., New York (New York U., 1959)
Simani, Rahmatollah, Oak Park, Ill. (Tehran, 1958)
Sinnott, John Jr., Red Bank, N.J. (Pennsylvania U., 1943)
Smith, George E., St. Louis (Louisiana State, 1952)
Smith, Hugh P. Jr., Boise, Idaho (Pennsylvania U., 1943)
Smith, Thomas W., Charlottesville, Va. (Tulane, 1964)
Smith, Warren D., Pittsford, N.Y. (Boston U., 1956)
Snape, William J. Jr., Winter Park (Jefferson, 1969)
Snyder, Donald, Woodmere, L.I., N.Y. (Hahnemann, 1961)
Snyder, James L., Jacksonville (Jefferson, 1961)
Spanier, Suzanne S., Gainesville (Florida U., 1969)
Spencer, Robert S., Hollywood (Temple, 1943)
Spil, Samuel, Rochester, Minn. (Havana, 1960)
Stanley, John A., Winston-Salem, N.C. (Harvard, 1958)
Stark, Stanley, Brooklyn, N.Y. (Middlesex U., 1945)
Stein, Samuel H., Willingboro, N.J. (Jefferson, 1933)
Stewart, Roger H., Fayetteville, N.C. (Michigan U., 1966)
Still, James A. Jr., Gainesville (Miami U., 1970)
Stoesser, Bruce C., Pensacola (S. U. N. Y., 1968)
Stone, James D., Memphis, Tenn. (Tennessee U., 1966)
Strauss, Jose, Miami (Buenos Aires U., 1955)
Sturgeon, Howard E., Fort Myers (Maryland U., 1956)
Stutchin, Abraham D., Dunedin (Albert Einstein, 1959)
Suarez, Horacio R., Lake City (Havana, 1949)
Suarez, Jose R., Hialeah (Havana, 1948)
Suarez, Miguel A., Key Biscayne (Havana, 1960)
Suarez-Mederos, Francisco, Miami (Salamanca U., 1967)
Sullivan, Donald C., Chicago (Baylor, 1962)
Sullivan, Raymond C. Jr., Pensacola (Florida U., 1969)
Sumikoshi, Kikuo, Chicago (Tohoku U., 1948)
Sutherland, Ian H., Tampa (Bristol U., Eng., 1964)
Sutton, Carl H., Miami (Indiana U., 1954)
Symington, Richard C., Randolph, Mass. (Mississippi U., 1969)

Taft, Charles V., Winter Park (Duke, 1968)
Tarabulcy, Edward, Riverside, Penn. (Alexandria U., 1946)
Taxin, Richard N., Sheppard AFB, Texas (Pennsylvania U., 1968)
Tenaglia, Thomas A., Lincoln Park, Mich. (Wayne State, 1937)
Thomas, Belmont E., Douglaston, N.Y. (McGill, 1936)
Thompson, Lawrence C., Mansfield, Ohio (Ohio State, 1948)
Thompson, William A., Jacksonville (Miami U., 1970)
Thurer, Richard J., Miami (Columbia U., 1961)
Tingle, William F., Evanston, Ill. (Indiana U., 1968)
Tisch, Allen, Newburgh, N.Y. (Louvain U., 1968)
Tomlinson, Sterling, Poughkeepsie, N.Y. (Trinity (Ireland), 1937)
Tredennick, Charles N., Butler, Penn. (Temple, 1960)
Treistman, Bernardo, Houston, Texas (Peruvian U., 1966)
Triana-Aguilar, S. H., Jacksonville (Colombia Nat'l U., 1959)
Troner, Michael B., Miami (S. U. N. Y., 1968)
Tronzo, Raymond G., Philadelphia, Penn. (Jefferson, 1957)
Tucker, Frank C. Jr., Pensacola (N. Carolina U., 1968)
Turk, Robert P., St. Petersburg (Alabama M. C., 1960)
Tydings, Lawrence H., Glen Oaks, N.Y. (S. U. N. Y., 1969)

Ugarte, Thomas R., Hialeah (Mexico City U., 1962)
Unzueta, Carlos A., Jacksonville (San Marcos U., 1964)

Valdes, Artemio R., Tampa (Havana, 1938)
Vallejo, Ivan D., Hialeah (Havana, 1961)
Vallejo, Sergio H., Lakeland (Havana, 1960)
Van Belle, Johanna H., Tallahassee (Toronto U., 1961)
Van Caneghem, Adrian, New York (Havana, 1952)
Vanderberry, Robert C. Jr., Orange Park (N. Carolina U., 1968)
Vargas, Agustin A., Rochester, N.Y. (Buenos Aires U., 1965)
Velazquez, Mariano, Orlando (Havana, 1946)
Vesey, William J., Indianapolis, Ind. (Indiana U., 1966)
Vidana, Orlando J., Miami (Havana, 1943)
Viera, Cristobal E., Miami (Miami U., 1970)
Vilardo, Ross U., Jacksonville (Palermo U., Italy, 1969)
Von Storch, Theodore K., Tampa (Cincinnati U., 1967)

Wainstein, Mayer L., Cleveland, Ohio (Ohio State, 1965)
Wallach, Robert T., New Rochelle, N.Y.(Pennsylvania U., 1943)

Watson, Randy C., Metairie, La. (Louisiana State, 1967)
Weber, John R., Fort Wayne, Ind. (Indiana U., 1943)
Weinberg, Bernhard J., Evanston, Ill. (Northwestern, 1942)
Weiner, Charles I., Baltimore (Maryland U., 1970)
Weinreb, Herbert L., Brooklyn, N.Y. (Washington, 1952)
Weinstein, Howard, Brooklyn, N.Y. (S. U. N. Y., 1957)
Weiss, Howard M., Staten Island, N.Y. (S.U.N.Y., 1957)
Wendler, Willis J. Jr., Perrysburg, Ohio (N. Y. M. C., 1952)
Wenger, Thomas J., Winter Park (Baylor, 1970)
West, Barbour D., Gainesville (Kentucky U., 1964)
Westervelt, Harold A., Orlando (Georgia M. C., 1963)
Westmoreland, Anon E. Jr., Cocoa Beach (Emory, 1970)
Whang, Jai C., Jacksonville (Seoul Nat'l U., 1965)
Whelchel, Alice S., Miami (Miami U., 1970)
Whelchel, Carl D. III, Jacksonville (Georgia M. C., 1967)
White, A. Burton, Great Neck, N.Y. (Hahnemann, 1949)
White, David W., Lynchburg, Va. (Virginia U., 1958)
Wiederhold, Wigbert, Columbus, Ohio (Albert-Ludwigs U., 1955)
Wigoda, Carlos, Houston, Texas (Mexico Nat'l U., 1966)
Wild, James H., San Antonio, Texas (Ohio State U., 1967)
Winn, Charles E. II, Pensacola (Florida U., 1970)
Winocur, Emanuel M., Paramus, N.J. (Buenos Aires U., 1955)
Wisch, Nathaniel, New York (Northwestern, 1958)
Wong, William, San Francisco (S. U. N. Y., 1965)
Wood, Herman C., Brewton, Ala. (Illinois U., 1951)

Yasrebi, Hosein, Jacksonville (Tehran, 1964)
Yasrebi, Reza, Wilmington, Del. (Tehran, 1962)
Young, Robert S., San Diego, Calif. (Johns Hopkins, 1966)
Youshaw, Dennis G., Eglin AFB (Hahnemann M. C., 1965)

Zann, Gregory J., Toledo, Ohio (N. Y. M. C., 1950)
Zalduendo, Carlos V., Oak Lawn, Ill. (Havana, 1960)
Zeifer, Herman D., Chappagua, N.Y. (Rochester U., 1943)
Zieverink, Sara E., Cincinnati, Ohio (Vanderbilt, 1968)
Zimmerman, Maurice J., New York (S. U. N. Y., 1958)
Zippin, George J., Schenectedy, N.Y. (Albany M. C. 1938)

Licenses to Practice Medicine in Florida Granted By Reciprocity or by Endorsement of Credentials

The Florida State Board of Medical Examiners report that 54 applicants have been issued licenses to practice medicine in Florida by reciprocity or by endorsement of credentials on January 14, 1972 in Tampa, Florida. The names, towns, medical school and year of graduation follow:

Aksu, Engin G., Middletown, Conn. (Istanbul, 1961)

Barrocas, Clara V., Key Biscayne (Salamanca, 1963)
Bevan, James L., Tucson, Arizona (Jefferson, 1963)
Bunyaviroch, Sunthorn, Bronx, N.Y. (Siriraj Hospital, 1964)

Cadena, Guillermo M., Chicago (Bogota, 1965)
Carlin, Mary E., Irving, Texas (Miami U., 1970)
Collins, Harold T., Orlando (Ohio State, 1968)

D'Andrea, Francis X., New York (Georgetown, 1969)
Danoff, Sherwood S., Brooklyn, N.Y. (N.Y. M.C., 1967)
Decker, Thomas J., Clearwater (Albany, 1969)
Ditmore, Quinton M., Pensacola (Oklahoma U., 1969)
Dober, Stanley, Miami (Albert Einstein, 1967)
Dodson, Marvin H., Chapel Hill, N.C. (U. of Florida, 1969)

Feldman, Howard L., Brookline, Mass. (Cornell, 1968)

Goldman, Gerald C., Ft. Leonard Wood, Mo. (Boston U., 1966)
Gordon, Kenneth A., Long Valley, N.J. (N. J. M. C., 1967)

Hinebaugh, Ronald E., Griffis AFB, N.J. (W. Virginia U., 1969)
Hurtado, Manuel M., Middletown, N.Y. (Trujillo Nat'l U., 1962)

Keller, Irvin B., San Antonio, Texas (Jefferson, 1964)
Kemper, Bennett I., Philadelphia, Pa. (Virginia M.C., 1967)
Kern, Eugene B., Rochester, Minn. (Temple, 1963)
Kramer, Dean C., Gainesville (Missouri U., 1966)
Kushner, Gary G., San Antonio, Texas (Jefferson, 1966)
Lane, Alan S., Crofton, Md. (S.U.N.Y., 1967)
Lehrer, Theodor, Fort Lee, N.J. (U. of Chile, 1961)
Lipton, Allan, Hershey, Pa. (N.Y. U., 1963)

Mabee, Grant W., Broadview Heights, Ohio (Queen's U. (Ont.), 1963)
Martone, Christine S., Tampa (Loyola, 1969)
Machemer, Robert, Miami (Freiburg U., 1959)
Mohammadbhoy, Kayum, Paterson, N.J. (Calcutta M.C., 1964)

Padow, Walter D., Montgomery, Ala. (Virginia M.C., 1964)
Paguaga, Norma E., Chicago (Nicaragua U., 1959)
Pattani, Jaykumar M., Jacksonville (India Ins., 1963)
Perez, Louis A., Yonkers, N.Y. (S.U.N.Y., 1966)
Pevsner, Norman H., Jacksonville (Chicago M.S., 1969)
Propsom, John T., Orlando (Marquette, 1969)

Rao, Katikineni V., Detroit, Mich. (Osmania, 1963)
Ray, Jerry L., Beaumont, Texas (Texas U., 1966)
Riley, Charles P., Birmingham, Ala. (Duke, 1965)
Roeck, Roger V., San Francisco (Louvain, 1957)
Roever, Frederick H., Philadelphia, Pa. (Hahnemann, 1966)
Roque, Juan L., Baltimore, Md. (Sevilla, 1965)
Ryan, Thomas F., Pensacola (Georgetown, 1969)

Sardesai, Prabhaker G., Bronx, N.Y. (Baroda U., 1963)
Shabanah, Fikri H., New Orleans (McGill, 1963)
Sibley, Richard H., Oklahoma City (W. Virginia U., 1967)
Smith, Robert T., Satellite Beach (S. C. M. C., 1970)
Stinson, Daniel T., Jacksonville (U. of Zurich, 1967)

Tabachnikoff, Robert M., W. Hartford, Conn. (S.U.N.Y., 1966)
Thieler, William R., Winter Park (Temple, 1965)
Thomas, Joseph T. T., Pensacola (Nebraska U., 1968)

Wagers, Lawrence T., New York (Vanderbilt, 1965)
Weinberg, Charles L., Fort Sill, Okla. (N.Y.M.C., 1965)
Wexler, Howard A., Miami (Rochester U., 1967)

Young, John G., Winter Park (Rochester U., 1968)
Young, Robert R., Lutherville, Md. (Maryland M.S., 1966)

Classified Ads

physicians wanted

Family Practitioners

FAMILY PHYSICIAN AND INTERNIST WANTED: To join specialty group in rapidly growing area. Salary and partnership negotiable. Excellent 450-bed new hospital. Contact James Morgan, M.D., 400 Avenue "K," S.E., Winter Haven, Florida 33880.

Specialists

INTERNIST, UROLOGIST, GP's.: Outstanding opportunities in progressive nonurban community serving 20,000. Write John H. Parker, M.D., Chief of Staff, Doctors Memorial Hospital, Perry, Florida 32347.

INTERNIST WANTED: For association, greater Miami area, Please send curriculum vitae to C-524, P.O. Box 2411, Jacksonville, Florida 32203.

ENT SPECIALISTS; To take over established practice, Orlando. July 1972 or sooner. Contact R.N. Serros, M.D., 95 West Columbia St., Orlando, Florida. Phone: 241-5339 or 184-4333.

BOARD ELIGIBLE OR BOARD CERTIFIED GENERAL SURGEON to join expanding comprehensive group of young well qualified family physicians and surgeons now consisting of board eligible surgeon, and three family physicians who are AOA. Service area of about 80,000 served by about ten M.D.'s; one of fastest growing in entire nation. Two hospitals with open staffs. Additional office space soon available. Above average guarantee against gross. 46-week year. Call or write to Joseph E. Abbey, M.D., P.O. Box 1058, New Port Richey, Florida 33552. (813) 842-8494.

PSYCHIATRIST: We are seaching for a full time Clinical Director, no age limit, with a Florida license, for immediate affiliation with an 86-bed accredited private psychiatric hospital. Contact G. F. Hardy Jr., Administrator, Coral Ridge Psychiatric Hospital, 4545 North Federal Highway, Fort Lauderdale, Florida. Tel.: (305) 771-2711.

WANTED: Urologist and Otolaryngologist to join expanding multispecialty clinic in central Florida. Fully equipped offices including x-ray; located near two hospitals. Must be board certified or board qualified. Send resume to Gil Slatton Jr., Administrator, Nancy Duane Memorial Clinic, 715 East Dixie Avenue, Leesburg, Florida 32728. Phone (904) 787-2124.

INTERNIST WANTED: Board eligible or certified, preferably with subspecialty, interest in hematology and/or gastroenterology to join flourishing practice in Fort Lauderdale area. Excellent salary and fringe benefits first year, leading to association. Must have Florida license. Please phone (305) 565-6434.

INTERNIST AND/OR GENERAL PRACTITIONER WANTED: To associate with general surgeon and Ob-Gyn partnership in Central Florida small town near Disney World and near new Barnum Bailey enterprise. Adequate salary first year—partnership second year. Send particulars to C-539, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST: Associate (age 32-45) wanted by pathologist boarded in Anat. and Clin., practicing internal medicine and clinical pathology on Florida East Coast near Fort Lauderdale. Very active, growing practice; fully equipped offices including large laboratory, x-ray; located near 4 hospitals. General internal medicine; sub-specialty desirable, but not mandatory. Must have military obligation completed. Excellent opportunity for eager individual who wishes to locate in this area. Curriculum vitae to C-538, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST WANTED: Specialty open; join partnership of three internists in Hollywood. One year salary, then partnership. Write C-540, P. O. Box 2411, Jacksonville, Florida 32203.

Miscellaneous

HOUSE PHYSICIANS—MEDICAL SERVICE: Orange Memorial Hospital is seeking Florida licensed and/or unlicensed Physicians on a full or part-time basis for Medical Services in 800-bed private non-profit hospital. Apply Director, Orange Memorial Hospital, 1416 South Orange Avenue, Orlando, Florida 32806.

WANTED IMMEDIATELY: Private emergency room physician. Corporate group needs fifth physician in teaching hospital, Orlando, Florida. Prefer GP. Florida license required. Contact Bruce S. Webster, M.D. (305) 647-5728 or Robert Gay, M.D. (305) 422-0159.

ADDITIONAL PHYSICIANS URGENTLY NEEDED: GP, internal medicine, obstetrics, pediatrics, and general surgery. Modern office immediately available. Contact I. B. Price, M.D., P.O. Box 819, Quincy, Florida 32351.

PHYSICIANS NEEDED: Tallahassee, Leon County, Northwest. General practitioners, internists and pediatricians in particular. Inquiries regarding practice in this community can be forwarded to J. Orson Smith Jr., M.D., Chairman, Physician Procurement Committee, 1433 Miccosukee Rd., Tallahassee, Fla. 32303. Phone (904) 877-1145.

DUNEDIN, Pinellas County, middle west coast, Clearwater area. Thirty-six physician multispecialty group seeking internist-gastroenterologist, neurologist, pathologist, obstetrician-gynecologist, GP, and emergency room physician. Affiliated general hospital just expanded to 308 beds. Clinic expansion to be completed January 1972. Long range plans for 650 beds and 75-physician clinic. No investment required. Contact Donald M. Schroder, administrator, Mease Hospital and Clinic, P.O. Box 760, Dunedin 33528, phone (813) 733-1111.

TIRED OF THE CITY RAT RACE? We are a small investor-owned hospital badly in need of a family physician. If interested, send resume to C-533, P.O. Box 2411, Jacksonville, Florida 32203.

IT HAPPENS EVERY DAY! Personalized medical I.D. necklaces can save a life. 5 lines of information on stainless steel, $1.99. Name, address, city, state, phone, Dr.'s name or phone, drug allergies or disease. McRoberts ID Co., 5541 Arlington Rd., Suite 1, Jacksonville, Florida 32211. Phone (904) 743-3855.

CENTRAL FLORIDA AREA: Lovely residential community just above Orlando and Disney World. Many lakes, water activities, and growing family living area! Excellent opportunity for one or two associates in unique, brand new medical center for family practice with OB; surgical privileges if desired at nearby modern 155-bed hospital. Florida license necessary and residency preferred. Initially, no expenses with guaranteed minimum plus percentage. Contact Randall B. Whitney, M.D., 1100 Morningside, Mount Dora, Florida 32757. Phone (904) 383-6129.

EMERGENCY ROOM PHYSICIAN wanted to cover noon Saturday to midnight Sunday on alternate weekends. Sleeping accommodations provided. Contact Administrator, Lake Wales Hospital, Lake Wales, Florida 33853.

WEBSTER DICTIONARIES: Library size, 1971 edition, brand new, still in box. Cost new: $45. Will sell for $15. Deduct 10% on orders of 6 or more. Mail to North American Liquidators, 1450 Niagara Falls Blvd., Dept. HH-125, Tonawanda, New York 14150. C.O.D. orders enclose $1 good will deposit. Pay balance plus C.O.D. shipping on delivery. Be satisfied on inspection or return within 10 days for full refund. No dealers, each volume specifically stamped not for resale. Please add $1.25 postage and handling. New York State residents add applicable sales tax.

situations wanted

LOCUM TENENS WANTED for the first two to three weeks of July. 35-year old pathology resident; 6 years experience general practice; 2 years experience emergency room work. Contact S. D. Bourgeois, M.D., Tulane University School of Medicine, Pathology Department, New Orleans 70112.

INTERNIST WITH SUBSPECIALTY IN ENDOCRINOLOGY, married, 32 years old is seeking association or group practice. Preferably around the Miami area, to begin July 1973. Six years of postgraduate training including two years of fellowship in endocrinology. Licensed in Florida and board eligible in internal medicine. Military exempted. Reply: J. Shuman, M.D., 2 Bayard Rd., Pittsburgh, Pa. 15213.

POSITION WANTED: Internist, board eligible, age 34, military obligation completed, Florida license and three years of excellent training desires partnership or group practice starting July 1972. Write C-548, P.O. Box 2411, Jacksonville, Florida 32203.

ALLERGIST, 42, certified pediatric allergy. Academic position university-affiliated hospital, head chest & allergy sections. Experienced chest disease, pulmonary function, tuberculosis, respiratory care, etc. Desires association with established practice, group, or consider progressive hospital lab. Prefer coastal areas. Inquiries: John McCloskey, M.D., 2380 Packard Ave., Huntingdon Valley, Pa. 19006.

practices available

ST. PETERSBURG, FLORIDA—ACTIVE MEDICAL PRACTICE and completely equipped office for rent or sale—includes fluoroscopy and x-ray, EKG, laboratory equipment. Centrally located in own building with off-street parking front and rear. Internist retiring. Contact Dr. S. Myerson, 3145-5th Ave., N. Tel: (813) 894-4763 or (813) 347-8908.

real estate

EXCELLENT OFFICE SPACE AVAILABLE: In the Five Points Medical Center, Oak and Lomax Sts., Jacksonville, Fla. 32204. All utilities and services furnished. For information please call Dr. Max Mendelson at 355-5150.

WATERFALL: Large wooded lot with spring fed, roaring mountain trout stream and waterfalls in North Carolina mountains. Airport 7 miles. Must be seen to be appreciated. Call (904) 388-7535 evenings and Sundays.

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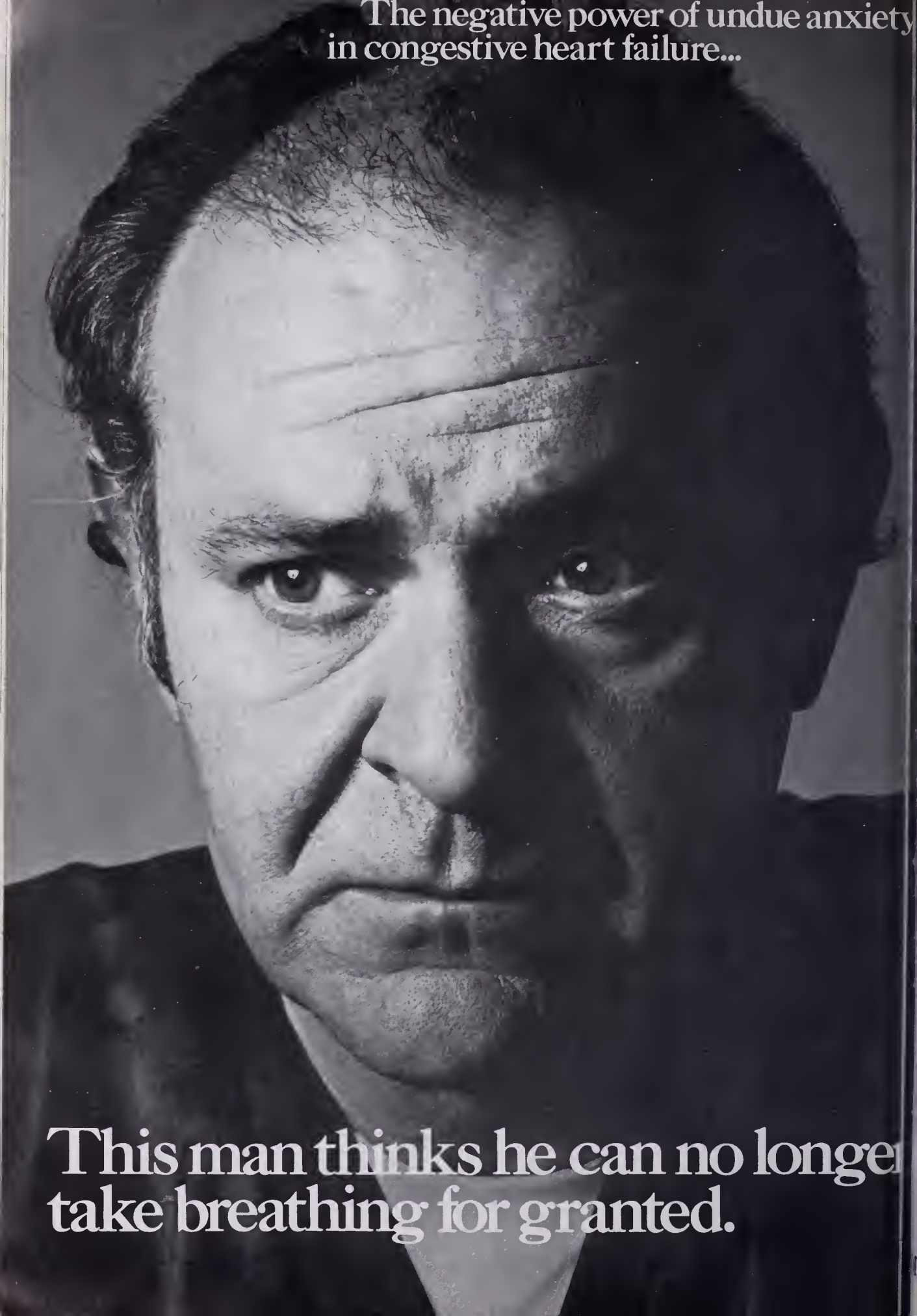
COLLEGE OF PHYSICIANS OF PHILADELPHIA

JUL 21 1972

MDS



PROCEEDINGS ISSUE


The negative power of undue anxiety
in congestive heart failure...
This man thinks he can no longe
take breathing for granted.

Typical of many patients with congestive heart failure, he also suffers from severe anxiety, a psychic factor that may influence the character and degree of his symptoms, such as dyspnea. His apprehension may also deprive him of the emotional calm so important in maintenance therapy.

Aid in rehabilitation

Specific medical and environmental measures are often enhanced by the antianxiety action of adjunctive Libritabs (chlordiazepoxide). Libritabs can also facilitate treatment of the tense convalescent patient until antianxiety therapy is no longer required. Whereas in geriatrics the *usual daily dosage* is 5 mg two to four times daily, the *initial dosage* in elderly and debilitated patients should be limited to 10 mg or less per day, adjusting as needed and tolerated.

Concomitant use with primary agents

Libritabs is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics, antihypertensives, vasodilators and oral anticoagulants, whenever excessive anxiety or emotional tension adversely affects the clinical condition or response to therapy. Although clinical studies have not established a cause and effect relationship, physicians should be aware that variable effects on blood coagulation have been reported very rarely in patients receiving oral anticoagulants and chlordiazepoxide HCl.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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JULY, 1972 • VOLUME 59 • NUMBER 7

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JULY COVER—The painting, entitled "The Door," by Dr. James D. Moody of Orlando, won the Editor's Award at the Woman's Auxiliary Sixth Annual Benefit Art Show during the FMA Annual Meeting, May 3-7, in Hollywood.

President's Page



What Happened in Hollywood?

Your delegates to the annual Florida Medical Association meeting in Hollywood in May, carried on your business in a most orderly manner, and I believe the meeting was very successful. The complete proceedings of the meeting are reported elsewhere in this issue of *The Journal*. It might be well worth your while to skim through them.

To me, the highlight of this meeting was the passage of the recommendation that the FMA set up a new corporation to be known as the Florida Physicians' Association, Inc. The resolution that passed stated "that the FMA organize and sponsor a corporation dedicated to the private practice of medicine in Florida; that the membership of this corporation be restricted to FMA members with voluntary participation; and that this corporation be directly responsible to the FMA. The corporation will be known as the Florida Physicians' Association, Inc."

The purposes and functions were outlined as follows:

1. Actively pursue a program to preserve the professional and economic independence of its members.
2. To advance further and protect the welfare of patients and physicians in private medical practice, and to preserve the integrity of their relationship.
3. To assert the physicians' responsibility and right to assess and determine their individual roles in the practice of medicine as well as their collective interests in the establishment and maintenance of high standards of medical care in the community as a whole.
4. To establish such organs, agencies and facilities as may be deemed necessary or desirable to represent and protect the membership as a whole and/or its individual members in transactions and/or relationships with any or all persons, parties, agencies and organizations who are third parties to the patient-physician relationship.
5. To take advantage of existing laws that protect organized groups acting in concert.
6. To promote the socioeconomic welfare of the physician.
7. To protect and strengthen the patient-doctor relationship, and to serve an an agent in matters involving third parties.

The above concept is extremely interesting and timely. Similar proposals have been made in the past, but apparently then the feeling of the physician was not right for beginning such an organization. From the grass roots level at this time, it would appear that the majority of our members are very anxious that such a corporation be established. By the time this appears in print, I hope that we will have a committee actively working on the legal aspects of such an organization. It would appear to me that the time has come when doctors must stick together and speak as one voice concerning any third party negotiation or any government program which seems to encroach upon our free enterprise system in the practice of medicine. I do strongly urge that you consider being a part of such a voluntary organization, and hope that you will see fit to join this association and support it to the fullest.

William J. Dean, M.D.

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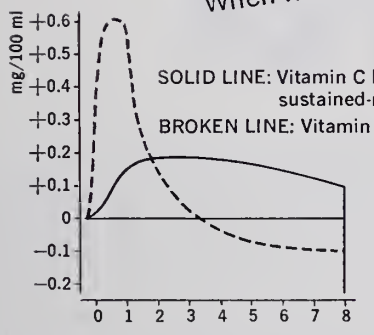


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1. Riccitelli, M. L.: Vitamin C Therapy in Geriatric Practice, J. Amer. Geriatrics Soc. 20: 34, 1972.

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Contraindications: History of hypersensitivity to thiabendazole.
Warnings: If hypersensitivity reactions occur, drug should be discontinued immediately and not resumed. Rarely, erythema multiforme has been associated with thiabendazole therapy; in severe cases (Stevens-Johnson syndrome), fatalities have occurred. Because CNS side effects may occur quite frequently, activities requiring mental alertness should be avoided. Safe use in pregnancy or lactation has not been established.
Precautions: Ideally, supportive therapy is indicated for anemic, dehydrated, or malnourished patients prior to initiation of anthelmintic therapy. In presence of hepatic or renal dysfunction, patients should be carefully monitored.
Adverse Reactions: Most frequently encountered are anorexia nausea, vomiting, and dizziness. Less frequently, diarrhea, epigastric distress, pruritus, weariness, drowsiness, giddiness and headache have occurred. Rarely, tinnitus, hyperirritability numbness, abnormal sensation in eyes, blurring of vision, xanthopsia; hypotension, collapse; enuresis; transient rise in cephalin flocculation and SGOT; perianal rash, cholestasis and parenchymal liver damage; hyperglycemia; transient leukopen malodor of the urine, crystalluria, hematuria; appearance of li Ascaris in the mouth and nose. Hypersensitivity reactions

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addendum

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Threadworm,* large roundworm,* hookworm,* and whipworm* disease	Two doses of 1 tablet/50 lb	Repeat the next day	Alternatively, a single dose of 2 tablets/50 lb may be given. However, a higher incidence of side effects should be expected.
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Use in conjunction with phenformin is indicated when optimal control is not obtained with Orinase or phenformin alone.

Contraindications: Orinase alone is not effective in juvenile or growth-onset diabetes nor in unstable brittle diabetes where insulin therapy is required.

Orinase should not be used: when diabetes is complicated by acidosis, ketosis, or coma, or when a history of repeated bouts of acidosis or coma is obtained; in the presence of other acute complications such as fever, severe trauma, or infections; and in patients with severe renal insufficiency. Insulin is indicated in these circumstances.

Pregnancy Warning: The safety and usefulness of Orinase during pregnancy has not been established either from the standpoint of the mother or the fetus. Animal studies have demonstrated feticidal and teratogenic effects of doses of 1,000-2,500 mg./kg./day, but application to human subjects unknown. Therefore, Orinase is not recommended for the pregnant diabetic, and when administering Orinase to women of childbearing age, these facts should be borne in mind.

Precautions: Diagnostic and therapeutic measures necessary for optimal control with insulin are also necessary with Orinase. The patient on Orinase must be fully instructed: about the nature of his disease; how to prevent and detect complications; how to control his condition; not to neglect dietary restrictions, develop a careless attitude or disregard instructions relative to body weight, exercise, personal hygiene, and avoidance of infection; how to recognize and counteract impending hypoglycemia; how and when to test for glycosuria and ketonuria; how to use insulin; and to report to the physician immediately if he does not feel as well as usual.

Caution, very close observation, and careful adjustment of dose are necessary when: insulin is withdrawn during the trial period in order to avoid ketosis, acidosis, and coma; thiazide diuretics are administered which may result in aggravation of diabetic state and increased tolbutamide requirement, temporary loss of control, or even secondary failure; treating patients with impaired hepatic and/or renal function and debilitated, malnourished, or semistarved patients in order to avoid severe hypoglycemia which may require corrective therapy over several days; and treating patients with severe trauma, infection, or surgical procedures where temporary return to insulin or addition of insulin may be necessary. Response to tolbutamide is diminished in patients receiving therapy with beta blocking agents.

As some diabetics are not suitable candidates, it is essential that the physician familiarize himself with the indications, limits of application, and selection of patients for therapy.

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cian daily, and during the first month report at least once weekly for physical examination and definitive evaluation. After a month, examinations are recommended monthly or as indicated. Appearance of ketonuria, increase in glycosuria, unsatisfactory lowering or persistent elevation of blood sugar, or failure to obtain and hold clinical improvement indicate nonresponsiveness to Orinase (tolbutamide). Orinase does not obviate need for maintaining standard diet regulation. Uncooperative patients should be considered unsuitable for therapy. Prescriptions should be refilled only on specific instruction of physician. In treating mild asymptomatic diabetic patients with abnormal glucose tolerance, glucose tolerance tests should be obtained at three- to six-month intervals. Orinase is not an oral insulin or a substitute for insulin and must not be used as sole therapy in juvenile diabetes or in diabetes complicated by acidosis or coma where insulin is indispensable.

If phenformin is prescribed in combination with Orinase, appropriate package literature should be consulted.

Adverse Reactions: Severe hypoglycemia, though uncommon, may occur and may mimic acute neurologic disorders such as cerebral thrombosis. Certain factors such as hepatic and renal disease, malnutrition, advanced age, alcohol ingestion, and adrenal and pituitary insufficiency may predispose to hypoglycemia and certain drugs such as insulin, phenformin, sulfonamides, oxyphenbutazone, salicylates, probenecid, monamine oxidase inhibitors, phenylbutazone, bishydroxycoumarin, and phenyramidol may prolong or enhance the action of Orinase and increase risk of hypoglycemia. Orinase long-term therapy has been reported to cause reduction in RAI uptake without producing clinical hypothyroidism or thyroid enlargement and at high doses is mildly goitrogenic in animals. Photosensitivity reactions, disulfiram-like reactions after alcohol ingestion, and false-positive tests for urine albumin have been reported.

Although usually not serious, gastrointestinal disturbances (nausea, epigastric fullness, and heartburn) and headache appear to be dose related and frequently disappear with reduction of dose or administration with meals. Allergic skin reactions (pruritus, erythema, urticaria, and morbilliform or maculopapular eruptions) are transient, usually not serious, and frequently disappear with continued administration. Orinase should be discontinued if skin reactions persist. Recent reports indicate that long-term use of Orinase has no appreciable effect on body weight.

Orinase appears to be remarkably free from gross clinical toxicity: crystalluria or other renal abnormalities have not been observed; incidence of liver dysfunction is remarkably low and jaundice has been rare and cleared readily on discontinuation of drug (carcinoma of the pancreas or other biliary obstruction should be ruled out in persistent jaundice); leukopenia; agranulocytosis; thrombocytopenia; hemolytic anemia; aplastic anemia; pancytopenia; and hepatic porphyria and porphyria cutanea tarda have been reported.

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Medical News

IRS Completes Study of Tax Law Compliance by Health Personnel

The Internal Revenue Service has completed a study of compliance with the federal tax laws by physicians, dentists, and other health care providers participating in Medicare, Medicaid, and certain private health benefit plans.

The study covered individuals receiving $25,000 or more during the year 1968 under the Medicare and Medicaid programs. The health care providers' receipts from all sources included in the study averaged $107,300. On an overall basis, 99 per cent of actual receipts were correctly reported on tax returns.

Business deductions averaged $45,100. Some 36 per cent of persons examined overstated their deductions, while 3 per cent understated them.

On an overall basis, 97 per cent of net profits were correctly reported. Errors from all sources—business receipts and business deductions, as well as nonbusiness income and deductions—resulted in proposed income tax deficiencies for over half of the health care providers examined.

Beginning January 1, 1971, commercial insurance companies, Blue Cross and Blue Shield organizations, and self-financed or self-administered health plans must record payments to health care practitioners under all private health insurance or prepaid benefit plans, as well as under public programs, such as Medicare and Medicaid. They must also file annual information returns with IRS reporting all payments aggregating $600 or more during the year.—*I.R.S. News Release No. 1134,* May 14, 1971

Dr. Lehman to Address Two International Conventions

David J. Lehman Jr., M.D., Hollywood, has been invited to address two international conventions on drug dependency in September: The International Council on Alcohol and Addictions in Amsterdam and the International Association for Accident and Traffic Medicine in Paris.

Symposium on Gynecological Malignancy

The 1972 Walter L. Thomas Symposium on Gynecological Malignancy and Surgery will be held at the Duke University Medical Center at Durham, N. C., September 15-16.

The program is being designed for practitioners and residents in obstetrics and gynecology, and there is no registration fee.

Information may be obtained from W. T. Creasman, M.D., Director of Gynecological Oncology, P. O. Box 3079, Duke University Medical Center, Durham, N. C. 27710.

ASIM Honors Dr. Borland

The American Society of Internal Medicine has named Jacksonville gastroenterologist James L. Borland Jr., M.D., as its "Young Internist of the Year."

Dr. Borland, 39, was nominated for the honor by the Florida Society of Internal Medicine. The award is presented by the 12,000-member ASIM to recognize outstanding contributions to the practice of internal medicine by physicians under 40.

A native of Florida, Dr. Borland received his B.S. degree from the University of Florida in 1954 and his M.D. from The Johns Hopkins University School of Medicine in 1958. His professional memberships include the Duval County Medical Society, the Florida Medical Association, the American Medical Association, ASIM, American College of Physicians and American Gastroenterological Association. He is an instructor in gastroenterology at the University Hospital of Jacksonville and is chief of the service at St. Vincent's Hospital.

Dr. Borland has published many articles on his specialty and is a member of the editorial board of *Gastroenterology*.

During the past year, Dr. Borland served as Chairman of the FMA Ad Hoc Committee on Health Maintenance Organizations which recommended policy guidelines for the development of HMOs in Florida. He also has served as President of the Duval County Foundation for Medical Care, Chairman of the FMA Subcommittee on Foundations and a member of the FMA Advisory Committee to Blue Shield and Fiscal Intermediaries.



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lthough not all clinicians agree on the value of vasodilators in vascular disease, several investigators[1-4] have reported favorably on the effects isoxsuprine. Effects have been demonstrated both by objective measurement[2,4] and observations of clinical improvement.[1,3]

mposition: VASODĪLAN tablets, isoxsuprine HCl, 10 mg. and 20 mg. **Indications:** In cerebral vascular disorders for relief of symptoms due to vas-lar insufficiency associated with various conditions such as arteriosclerosis and hypertension. In peripheral vascular disorders for relief of symp-ms such as intermittent claudication, coldness, numbness, pain and cramping of the extremities—in the management of arteriosclerosis obliterans, ıbetic vascular diseases, thromboangiitis obliterans (Buerger's disease), Raynaud's disease, postphlebitic conditions, acroparesthesia, frostbite ndrome and ulcers of the extremities (arteriosclerotic, diabetic, thrombotic). **Dosage and Administration:** In peripheral and cerebral vascular dis-ders—10 to 20 mg. three or four times daily. **Contraindications and Cautions:** There are no known contraindications to oral use when administered recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding. **Adverse Reactions:** On rare occasions, al administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. casional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose. **Supplied:** Tablets, 10 mg.—bottles 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500 and Unit Dose.

References: (1) Clarkson, I. S., and LePere, M.: Angiology *11*:190-192 (June) 1960. (2) Horton, G. E., and Johnson, P. C., Jr.: Angiology *15*:70-74 (Feb.) 1964.) Dhrymiotis, A. D., and Whittier, J. R.: Curr. Ther. Res. *4*:124-128 (April) 1962. (4) Whittier, J. R.: Angiology *15*:82-87 eb.) 1964.

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Dean's Page

An Integrated Program for a Three-Year Curriculum at the University of South Florida College of Medicine

Donn L. Smith, M.D.

There has been much discussion and consideration pro and con relative to the merit of a three-year curriculum in the schools of medicine across the country. Many of the more conservative members of the academic community have been strongly opposed to this concept. As a new College of Medicine our faculty has had an excellent opportunity to innovate in matters relating to the curriculum, instructional programs and in the areas of learning resources.

Following an intensive faculty study, and with student input available, it has been decided to conduct our program within a three-year curricular framework. While it is apparent that the three-year curriculum does not achieve a large increase in the numbers of graduates, it clearly allows each graduate one additional year of productivity in the active delivery of health care. Each 100 graduates will thus ultimately contribute 100 man-years of additional medical practice. Another significant factor is the year-round use of expensive facilities. The faculty has recognized the problem of the very long time period currently involved in the production of the completely trained physician graduate and feels that the reduction of the undergraduate time by one year is a useful and desirable objective. Postgraduate training periods are unlikely to be shortened and indeed may increase in the near future.

It is recognized by the faculty that certain disadvantages may be inherent in the shortened curriculum. The student may be squeezed into a too rapid progress through the wealth of material to be learned. Insufficient time may be allowed for deliberate thought and assimilation of subject matter. There may be a need in the case of some students for an additional year of maturation before undertaking graduate training. For these reasons either the faculty or individual students at this institution may, if cogent reasons are demonstrated, elect to require or allow a four-year period in individual cases.

For the school and the faculty, a serious problem is presented by the obligations to the faculty for research activities, opportunities for scholarly work, and vacations. Additional faculty with strong faculty-student ratios will be required if normal faculty responsibilities and opportunities are not to be sacrificed in the face of pressures resulting from constant year long instructional responsibilities. Great premium will be placed on interdepartmental coordination and unnecessary duplication of effort for both students and faculty will be reduced to a minimum. A more efficient utilization of faculty manpower will result. After careful consideration of the advantages and disadvantages the decision has been made to present our program in the three-year mode.

The instructional program will consist of a total of 33 calendar months in a three-year period which will include 5,200 hours of faculty-student contact in lectures, conferences, laboratories, and in the patient care areas. The curriculum which has been devised by the faculty begins with an eleven month segment of basic science work plus clinical correlations and a course entitled "Introduction to Medicine." This segment is followed by 22 months of clinical and elective education. It is anticipated that over 90 per cent of elective work will be in the clinical sciences.

The scheduled instruction is designed in the following time frame:

> First Eleven Months—Basic Sciences with Clinical Correlates; Pathology; Clinical Laboratory Medicine; Introduction to Medicine, and Physical Diagnosis
>
> Second Eleven Months—Clinical Clerkships—rotations in Internal Medicine; Surgery; Pediatrics; Obstetrics/Gynecology, and Psychiatry

Dr. Smith is Director of the Medical Center and Dean of the College of Medicine, University of South Florida, Tampa.

Third Eleven Months—Electives which will include numerous indepth clinical work in all specialties and subspecialties and in the basic sciences.

A comparison of contact hours between our original four-year curriculum and the new three-year curriculum indicates that the total contact hours in the four-year program was 5,310 hours. In the three-year program contact hours total 5,200 hours. Of the three-year total, 3,680 hours are spent in clinically-oriented instruction. This represents no decrease in the hours spent in the clinical sciences during the three-year program. The overall difference in contact hours is a relatively small figure of approximately 100 hours.

Additional consideration must be given to the questions of the student's ability to assimilate and mature and whether or not the faculty can engage in sustained teaching without significant loss of productive scholarly activity. Answers to these two questions are not totally predictable in advance. Therefore, a careful, almost day-to-day monitoring of the teaching, learning and scholarly productivity within the institution will be undertaken during the next three years in an effort to obtain meaningful data relative to these questions. The appropriate personnel will be made available for this purpose.

It is important to reiterate that any student may, for cogent reasons, elect to extend his period of study to four years, and by the same token, the faculty may for cause, require a given student to remain in the four-year mode. Next year's class and those subsequently selected will enter the college under these conditions. Over a reasonably short period of time we feel that an accurate assessment of the merits of this program will be possible. Should meaningful evidence become available at any time that the program is not producing the desired results, it will be changed in the appropriate manner.

In conclusion, it is my feeling that while change for change's sake is not a desirable way to go, there should be an opportunity for carefully planned and controlled excursions into new ways of conducting medical education. A new College of Medicine can provide the setting for productive change and educational progress with somewhat fewer difficulties than may be encountered in older institutions.

▸ Dr. Smith, University of South Florida, Tampa 33620.

A Modern Psychiatric Hospital . . .



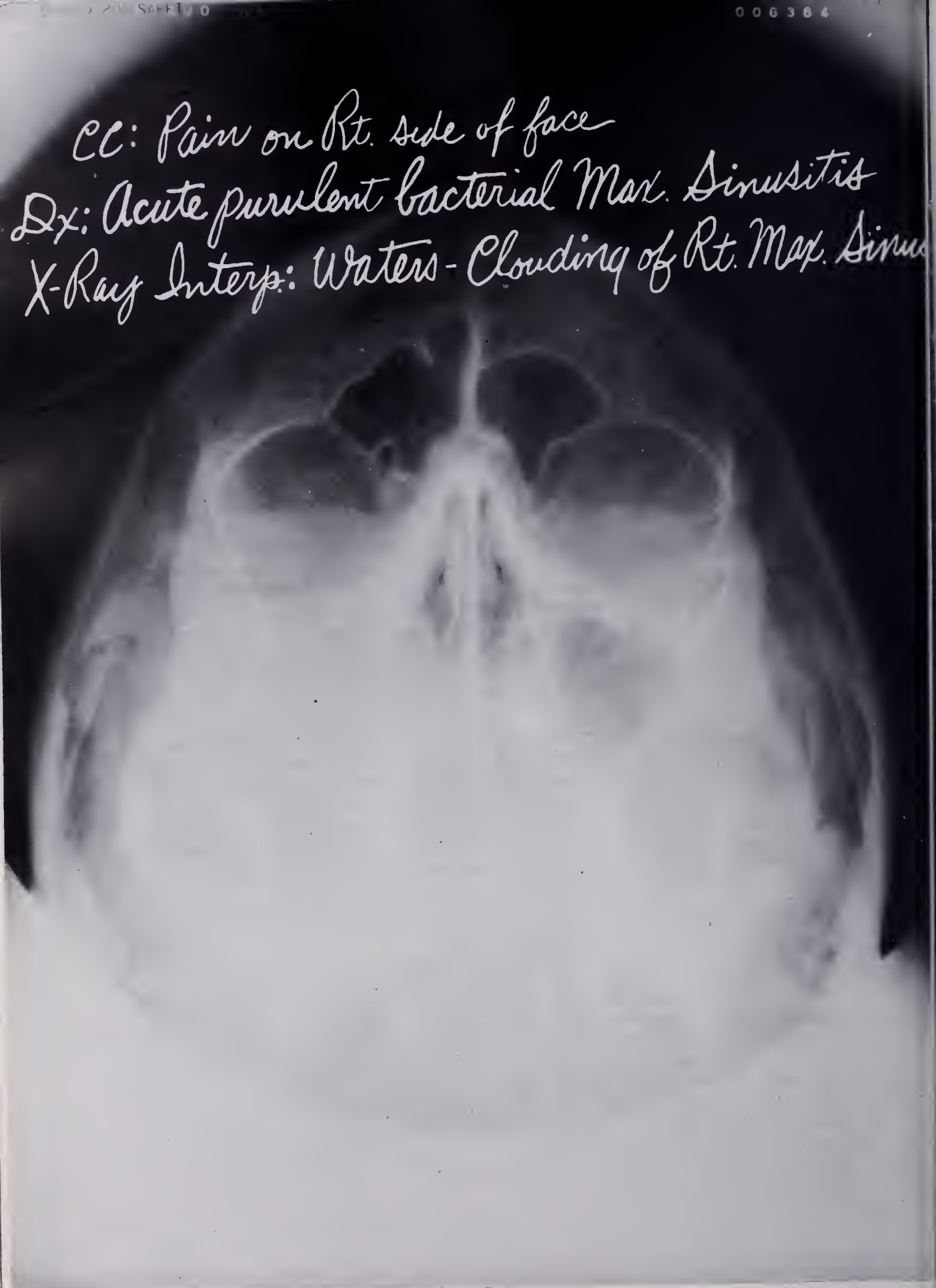
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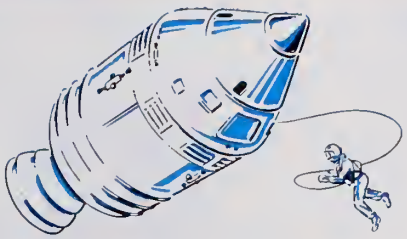
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PROCEEDINGS

Ninety-Eighth Annual Meeting—Florida Medical Association, Inc.

Hollywood, May 3-7, 1972

President's Address

FLOYD K. HURT, M.D.

Mr. Speaker, Members of the House of Delegates, Colleagues, Distinguished Guests—we are at the end of one of the most active years in the history of the Florida Medical Association. At the same time, we are at the threshold of a new year that promises to place even greater demands upon our officers, our Board of Governors, our councils and committees, and our staff. I believe that we are fit to meet the challenges that lie ahead.

Carrying out the policies and programs of the FMA has not been a one-man show. As your President, I have been blessed with an exceptional Board of Governors, dedicated council and committee chairmen and many other cooperative individuals on down through the ranks. Much of the story of the Florida Medical Association for the past year is written in your House of Delegates Handbook. The final chapters of FMA Year 1971-1972 will be written here in this hotel . . . in the reference committees and during the second and third sessions of the House of Delegates. There are, however, some matters I wish to comment upon today.

I think that when we talk about the problems, activities and programs of the Florida Medical Association, we must think of them in the context of our burgeoning population in Florida. The 1970 federal census shows that during the 1960s, our population increased by more than one-third. This was by far the greatest growth of any state east of the Mississippi River. And among all the states, our growth rate was second only to that of Nevada. As a result of growth, four additional Florida markets have been classified for the first time as Standard Metropolitan Statistical Areas. These are the Daytona Beach, Sarasota, Fort Myers and the Lakeland-Winter Haven Areas. We have grown from the 20th state in population to the ninth largest state since 1950. There is every reason to believe that our growth will continue at a rapid pace. Twenty-one per cent of our population—one of every five—are sixty-five years



President Floyd K. Hurt, M.D., Jacksonville, delivers his Presidential Address.

of age or older. Our proportion of senior citizens is the highest in the nation. Our under twenty-one population is among the lowest.

Last fall, one of the largest amusement centers ever known to man opened in central Florida. It is drawing tens of thousands of visitors every day. The construction industry is humming all over Florida. Our profession is growing along with the general population pattern. In the year 1950, our Board of Medical Examiners issued 325 licenses. Last year, 2,095 licenses were issued, including the first by endorsement. Ten years ago, in 1962, we had about 5,500 licensed physicians in Florida serving a population of a little less than five and one-half million. Last year, we had more than 9,200 doctors serving about seven million people. So, it would appear that growth in our physician population is exceeding that in our general population.

In recent years, we have seen several steps taken to liberalize our medical licensure law. There was the death of the basic science examination. Then there was the relaxation of the citizenship requirement. And finally, licensure by endorsement. These acts have lured physicians to Florida by the hundreds. Where are they going? To Dade County, to Palm Beach County, to Broward County—not to the places where they are needed most. Four counties have no doctor at all and several have only one or two. Our statewide computations indicate that we have one patient care doctor for every 826 population, which in my opinion is a favorable ratio. Ours is a problem of distribution. Dade County has roughly 2,500 doctors now. If you take one away, he will be missed by his colleagues and his patients. But the overall effect on medical care in Dade County would be extremely slight. But take this same physician, put him into practice at Perry, or at Madison, or at any of several other rural communities, and the effect of his professional presence is felt almost immediately. And so we have enough doctors in Florida. We just don't have them in the right places. Anyone who believes that lowering our licensure standards is going to solve the problem is just fooling himself. The National Health Service Corps, in which the FMA is cooperating, is making a very modest attack on the rural doctor shortage problem. Under this program, several Florida communities in need of medical services, including Belle Glade and Immokalee, have received, or will receive, Health Service Corps physicians and allied health personnel. (Dr. Hurt showed slides regarding the growth in the physician and general population in Florida in recent years; and receipts and expenditures of the FMA.)

During the legislative session that ended last month, we won a few and we lost a few. But I am proud to note that we had a very good batting average. We won passage of legislation to exempt members of review committees from liability as a result of their actions on these committees. We are hopeful that this may help to ease somewhat the problem we are experiencing in the area of professional liability today. The therapeutic abortion bill passed by the Legislature confirms generally with FMA policy, but *no* residency requirement is included in the law. We tried hard, but we were not able to bring our healing arts accreditation bill to a vote in the House, nor were we able to get physicians exempted from jury service. The Association was involved, at least to a minor extent, in about 200 pieces of legislation. A look at the record will show that our position was sustained more often than not. This is a tribute to our Capital Office, our key contact physician program, and our Committee on State Legislation, all under the capable direction of Dr. Sanford Mullen.

A major piece of health legislation produced this year authorizes the establishment of Health Maintenance Organizations (HMOs) in Florida. Dr. Jim Borland did an outstanding job as Chairman of our Ad Hoc Committee on Health Maintenance Organizations. This Committee worked with members of the Florida Legislature to assure that the legislation in this field would be rational. The Legislature, treading into a new area, welcomed our advice. Some legislators even asked us for suggestions. I am pleased to report to you that the HMO Act of Florida conforms to the FMA policy. Our Committee on HMO's is recommending that it be discharged and that its functions be assigned to the Subcommittee on Foundations for Medical Care. This would eliminate a certain amount of duplication of effort. Along these same lines, I would like to call your attention to another development regarding HMO's. Several weeks ago, the Florida Regional Medical Program approached the FMA regarding a proposed study of HMO's in Florida. We were asked if we would like to do it. Drs. Jim Walker and Jim Borland were designated as co-chairmen. They got together and drew up a list of functions and objectives, and on that basis, the contract was negotiated.

You may remember last year's debate over what is a safe level of mercury content in fish. The Florida Department of Natural Resources came to us and asked us to do a study on this subject. We appointed an Ad Hoc Committee on Environmental Problems of Mercury. This committee, headed by Dr. John E. Davies of Miami, investigated and made an excellent report which was submitted to the Department.

After three years of considerable work, the 1971 Florida Relative Value Schedule was distributed to the membership. Dr. Fred Butler's RVS Committee has taken some flak on this, but I personally think it has done an outstanding job and is to be congratulated.

The Committee is aware that certain procedures and figures will be outdated or were not included. Therefore, it is doing something that has not been done before—continuing its work to keep the RVS up-to-date. Our 1971 RVS has one characteristic that distinguishes it from all other previous studies. Actual surveys of physician fees were used. For that reason, the 1971 Florida Relative Value Studies is the *fact* book, not a *wish* book.

Fees paid through the Florida Workmen's Compensation Program have been a matter of continuing concern to us. Progress in this area has been slow, but we have been told that some adjustments will be made shortly. I commend to your attention the report of Dr. Joe Matthews' Subcommittee on Workmen's Compensation, which is in your Handbook.

Here in Florida, we still have a Medicaid Program that is unfair to both our indigent population and to the doctors who treat them. Our fees under this program are still being cut.

We have gotten no real satisfaction from the petition we filed with Secretary Richardson for review of the Florida Program. We may go to court to get this injustice corrected, and this possible course of action has been under continuing review by our attorneys.

Another act of government which we feel is discriminatory concerns Phase Two of the Economic Stabilization Program. We have protested to the Chairman of the Federal Price Commission about the provision restricting fee increases to 2½ per cent. We have contemplated a court challenge of this restriction, but we are told that the general climate for this type of thing is unfavorable.

We do have some good news on the legal front to report. As many of you know, the FMA, the Jackson Memorial Hospital in Pasco County, and its medical staff were defendants in an antitrust suit. The plaintiffs were two osteopaths and a lay person. A federal appellate court has sent the case back to Tampa federal court, and we are now awaiting the formal dismissal order.

Several months ago on yet another legal matter, our state attorney general rendered a rather surprising opinion. In effect, he said that if you are on the medical staff of a public hospital, and if you are on the governing board of the same hospital at the same time, you are violating the conflict of interest law.

Two of my colleagues in Jacksonville were in just such a position at the University Hospital. With the encouragement and assistance of the FMA, these two members filed suit in Duval Circuit Court. In a summary judgment, the judge declared that there is no conflict, thus upholding our position and not that of the attorney general.

I would like now to say a few words about a matter of great concern to every physician in this room. I refer to your FMA Professional Liability Insurance Program. During the year, this program generated more trouble and seemed to be on the verge of collapse before our very eyes. Nine years ago, the program covered less than 200 doctors. Today, the enrollment is more than 4,000. This has become a big business. Because of this, we are determined that the program will maintain its integrity despite the troubles that have befallen it. I do not have to remind you that as more and more liability suits are filed, your premium rates have increased. Add this to the fact that there are other insurers writing liability coverage for what they consider lower risks, excluding Dade and Broward Counties. This, of course, amounts to a raid on our own program and has an adverse effect on our rate structure. I want to assure you that your Association will take steps to prevent further erosion of the base of our program.

I think perhaps one of the most remarkable activities of your Association has been its peer review program. I had the opportunity to watch our Peer Review Committee in action this year, and I was quite impressed. This Committee, under the leadership of Dr. Jim Byrne of Miami, is among the most dedicated and conscientious in our FMA committee structure. In its concept, there can be little valid objection to peer review. But the manner in which it is sometimes performed might bear scrutiny. Our Committee continues to improve this aspect of peer review. This is one

reason, I think, that our peer review program in Florida, particularly as it relates to Medicare, is a model for others. I believe that medicine must develop and maintain truly effective peer review mechanisms. It can be one of our most effective defenses against further government encroachment upon our profession.

Another defense relates to our continuing medical education. This entails how we demonstrate our competence, how we show we are up-to-date with advances in medicine 15, 20 or 30 years after graduation.

During this meeting, this House of Delegates will act upon a recommendation that physicians be required to meet minimum standards of continuing education or else forfeit their FMA membership. This recommendation comes from your Committee on Continuing Education and is approved by your Board of Governors. This concept is not new. Several other state medical associations have established generally similar programs, and the American Academy of Family Practice has had it for years. The recommendation before you is that 30 hours of education be established as the minimum standard for each year. I would recommend that you endorse this concept and direct the Committee on Continuing Education to come back one year from now with a detailed plan for implementation. Such a program probably would entail the addition of at least one other staff person and other additional expenses. The Committee's proposal, then, should also include a recommendation as to how it could be financed.

Our Subcommittee on Quackery, headed by Dr. Frank Agee, has been enlarged and has been gearing up for an active program against various forms of quackery. It has asked our component societies to form local quackery committees and the response has been gratifying.

I would call your attention to the fine work being done by our Ad Hoc Committee on Drug Abuse. This Committee is two years old, and has members from the legal, church, law enforcement, education and other professions as well as our own. Chairman Bob Johnson remarked in his address at Orlando in January that Miami is now the nation's leading port of entry for illicit drugs. I think this fact underscores the importance of this Committee and our involvement in its work. I regret very deeply that Dr. Johnson has found it necessary to step down as Chairman of that Committee. However, he will continue to contribute as a member of the Committee.

In your Handbook you will find recommendations of the Ad Hoc Committee on the Structure of the FMA. This Committee has functioned under the able leadership of Dr. Joe Matthews, who so skillfully handles our negotiations with Workmen's Compensation.

Our Judicial Council and the Committee on Membership and Discipline which serves under it have been exceptionally active in the past year. I want to say that Dr. Vince Corso and the four other men on that Council are among the very finest gentlemen I know. Their workload has increased to the point that they are now meeting at least four times a year for two days. I cannot overemphasize the importance of our Judicial Council in maintaining the honor and dignity of our profession.

More and more work has been piled on our Membership and Discipline Committee. These men likewise have faced many unpleasant situations in the discharge of their duties. For the past year they have been involved in our statewide survey of billing arrangements of hospital-based physicians. There have been two objectives of this study. The first is to determine in what hospitals and in what departments physicians and hospitals participate in combined billing. The second objective is to encourage physicians on combined billing to switch to separate billing. Unfortunately, we have found that some would rather fight than switch.

All of you know that the American Medical Association in the last year or so has been experiencing a decrease in membership. This has not been an extremely serious problem in Florida. Our decrease in AMA membership has been slight. However, it has caused me some concern. With all its imperfections, I believe the AMA can be and is the most effective voice of medicine at the national level. Please do not desert it. The AMA needs you.

This, then, is part of the story of the past year and a preview of some of the things we will be doing during the next few days.

I wish to thank Harold Parham and his excellent FMA staff, my associates, and of course, my wife, Veronna. To all of them, I owe much.

As for me, being President of the Florida Medical Association has been a job as well as an honor.

Believe me, I've had a lot of fun doing it.

Thank you for the privilege of serving you.

General Session

The General Session of the 98th Annual Meeting of the Florida Medical Association was called to order at 11:00 a.m. on Friday, May 5, 1972, in the Regency Room of the Diplomat Hotel, Hollywood, Florida, by President Floyd K. Hurt, M.D.

Dr. Hurt announced the winners of the awards for scientific exhibits.

1972 Scientific Exhibit Awards

First Place: Fredric W. Pullen II, M.D., and L. Alan Smith, B.S., Miami: "Otologic Disease in Family Practice"

Second Place: Francisco Civantos, M.D., John di Bella, M.D., Carlos J. Dominguez, M.D., and Arkadi M. Rywlin, M.D., Miami Beach: "Protein Immunoelectrophoresis"

Third Place: Ralph E. Peterson, M.D., and William J. Bailey, M.D., Naples: "Treatment of Snake Bite"

Honorable Mention: Paul L. Goethals, M.D., Winter Park: "Referred Otalgia"

Dr. Hurt introduced the Guest Speaker, The Honorable Reubin O'D. Askew, Governor of the State of Florida.

Governor Askew directed his remarks toward the problem of meeting the medical care needs in the State of Florida including the maldistribution of doctors, rising hospital and medical costs and our current nursing home situation. He called attention to recent action by the Florida Legislature regarding the HMO approach and the certificate of need for hospitals and other health facilities, which was brought about because of overbuilding of these facilities. With respect to action by the Legislature removing restrictions on the establishment of so-called "Health Maintenance Organizations" in Florida the Governor favored the concept and hoped that this would not be opposed simply because it is new. He encouraged the founding of and physicians' service on HMO's and stated that he intended to explore the possibilities of establishing an HMO for state employees and for Medicaid patients as well. The Governor pointed out that he realized there were questions to be answered before commitments could be made to this approach. In his address Governor Askew announced that he had asked Emmett Roberts, Secretary of the Department of Health and Rehabilitative Services, to hold a conference to help identify our health and medical problems, with physician involvement. The Governor also discussed present activities in the areas of comprehensive health planning, the statewide system of family planning services and emergency medical services. In his closing remarks Governor Askew asked the doctors of Florida "to accept the responsibility and set yourselves to the task and goal of furnishing health care to all our citizens."

A ceremony was held for the presentation of Dr. J. Y. Porter's watch, Florida's first health officer, by the Florida Division of Health to the St. Augustine History of Medicine Museum.

Dr. Hurt introduced Wilson T. Sowder, M.D., Florida Health Officer; Mrs. Jessie Porter Newton, granddaughter to J. Y. Porter, M.D.; and James J. DeVito, M.D., representing the Historic St. Augustine Preservation Board—History of Medicine Museum in St. Augustine. Dr. Sowder gave a brief history and demonstrated the beautiful chimes of the diamond-encrusted watch which had been presented to Dr. Porter by the Jacksonville Auxiliary Sanitary Association in 1889 for his service to the people of Jacksonville during the Yellow Fever Epidemic in 1888. Mrs. Newton stated that this watch depicted her grandfather's devotion, love and dedication. Dr. Sowder, State Health Officer, who had received this historical timepiece for preservation in 1959 from J. Y. Porter IV, at this time passed the watch to Governor Askew. Governor Askew accepted the watch, which was being transferred as a result of recently enacted legislation in order that it may

be displayed for the people to look at and to examine. The Governor presented Dr. Porter's watch to Dr. DeVito who received it on behalf of the Historic St. Augustine Preservation Board —History of Medicine Museum in St. Augustine.

Mrs. Wesley S. Nock, President of the Woman's Auxiliary to the Florida Medical Association, presented a donation from the Auxiliary to Dr. DeVito for the appropriate encasement of the timepiece.

The President adjourned the General Session at 11:50 a.m.



State Health Director Wilson T. Sowder, M.D., Jacksonville, displays the famous gold watch that was owned by the late Joseph Y. Porter, M.D., Florida's first health officer. Mrs. Jessie Porter Newton (left), granddaughter of Dr. Porter, attended a ceremony held during the Annual Meeting, at which the watch was presented to the History of Medicine Museum in St. Augustine.



State Health Director Wilson T. Sowder, M.D., Jacksonville, demonstrates to the General Session the beautiful chimes of the gold pocket watch which once was carried by the late Joseph Y. Porter, M.D., Florida's first health officer. Gov. Reubin Askew (third from left) presented watch to James J. DeVito, M.D., St. Augustine (center) for placement in the History of Medicine Museum in that city. Also participating in the ceremony were Mrs. Wesley Nock, Coral Gables, President of the Woman's Auxiliary to FMA; and FMA President Floyd K. Hurt, M.D., Jacksonville.

First House of Delegates

The First House of Delegates convened at 4:05 p.m. on Wednesday, May 3, 1972, in the Regency Room of the Diplomat Hotel, Hollywood, Florida, with Dr. Charles K. Donegan, Speaker of the House, presiding.

The House was opened with a musical presentation by the Stranahan Singers, from the local Stranahan High School directed by Miss Peggy Barber, which concluded with a medley of patriotic songs.

The invocation was given by Dr. W. Dean Steward, Past President, of Orlando.

Dr. Steward: "May we rise please. Almighty God, our Heavenly Father, at the opening of this 98th Annual Meeting of the Florida Medical Association we pray that you will be with us and guide us. May all of our deliberations and activities be such as to find favor in your sight and may they be consistent with the high principles of medicine in Florida, dedicated to the health of the people of Florida, carried out with fairness to all. We ask these things in the name of the Great Physician, Jesus Christ. Amen."

The Speaker announced the membership of the Credentials Committee: Drs. Rowland E. Wood, Chairman, and Richard B. Moore.

The Chairman of the Credentials Committee, Dr. Wood, reported a quorum of 163 delegates present out of a possible 200, representing a majority of the delegates and a majority of the component medical societies, and moved that the delegates be seated. The motion carried.

Delegates

ALACHUA—John W. Andrews, Henry J. Babers, George A. Dell, David M. Drylie, William C. Ruffin.
BAY—James D. Nixon (Absent—W. Roland McArthur).
BREVARD—John T. Blackburn, T. John Kaminski, Paul Popovich, Joseph C. Von Thron.
BROWARD—Robert L. Andreae, Russell B. Carson, Ray E. Murphy, James B. Perry, Thomas F. Regan, W. Dotson Wells (Absent Milton P. Caster, Richard S. Doyle, Joseph E. Gelety, Paul E. Gutman, Mark A. R. Kuhn, David C. Lane, J. Gordon McAllister, Henry D. Perry Jr., John I. Williams).
CHARLOTTE—(Absent—Robert Palmer).
CLAY—(Absent—William A. Mulford).
COLLIER—Fred A. Butler, Nicholas H. Kalvin.
COLUMBIA—(Absent—Frank E. Adel).
DADE—Marvin Baker, Jerome Benson, Rufus K. Broadaway, Harvey E. Brown, Manuel L. Carbonell, Richard C. Clay, Jack Q. Cleveland, Francis N. Cooke, Vincent P. Corso, DeWitt C. Daughtry, O. William Davenport, Joseph H. Davis, Richard C. Dever, Robert F. Dickey, Rudolph E. Drosd, Miguel Figueroa Jr., Joseph Fitzgerald, Richard M. Fleming, M. Eugene Flipse Jr., Henry C. Hardin Jr., George Ioannides, Walter C. Jones III, John B. Liebler, Ronald J. Mann, Charles A. Monnin Jr., Sheldon Munach, Richard Ravel, Robert Schiess, M. Murray Schechter, Daniel Seckinger, Everett Shocket, Chauncey M. Stone, Mario M. Stone, William M. Straight, Charles F. Tate, Maynard Taylor, Arthur W. Wood Jr., Scheffel H. Wright, Nelson Zivitz (Absent—Sol Colsky, Edward W. Cullipher, Victor D. Dembrow, Marshall Hall, Paul S. Jarrett).
DESOTO-HARDEE-GLADES—Calvin W. Martin.



Mr. John M. McCarty (extreme left), President of the Florida Bar, addresses the House of Delegates at its opening session. At speaker's table are (left to right): James T. Cook, M.D., Marianna, Immediate Past President; Franklin J. Evans, M.D., Coral Gables, Vice Speaker of the House; Charles K. Donegan, M.D., St. Petersburg, Speaker of the House; Mr. W. Harold Parham, Jacksonville, Executive Vice President; Floyd K. Hurt, M.D., Jacksonville, President; James W. Walker, M.D., Jacksonville, Secretary-Treasurer; William J. Dean, M.D., St. Petersburg, President Elect; Ray E. Murphy Jr., M.D., Pompano Beach, Vice President; and Mrs. Wanda Bain, Director of the FMA Department of Administrative Services who recorded the proceedings, (not shown, Miss Louria Neel who transcribed the proceedings).

DUVAL—Warren M. Barrett, Clyde M. Collins, Thomas S. Edwards, Emmet F. Ferguson Jr., Karl B. Hanson, M. Harlan Johnston, Leonard E. Masters, Thad Moseley, Harry W. Reinstine Jr., John A. Rush Jr., Guy T. Selander (Absent—Albert H. Wilkinson Jr.).
ESCAMBIA—Charles J. Kahn, Philip B. Phillips, Theodore J. Marshall, William M. C. Wilhoit.
FRANKLIN-GULF—Joseph P. Hendrix.
HIGHLANDS—Donald C. Hartwell.
HILLSBOROUGH—Ernest R. Bourkard, Frank C. Coleman, Richard G. Connar, Irving M. Essrig, John C. Fletcher, Victor H. Knight Jr., Thomas E. McKell, William W. Trice, Henry L. Wright Jr., (Absent—Richard S. Hodes).
INDIAN RIVER—Charles C. Flood.
LAKE—J. Basil Hall, Thomas H. Nichols.
LEE-HENDRY—Larry P. Garrett, Francis L. Howington, Edward W. Salko.
LEON-WAKULLA-JEFFERSON—Edward G. Haskell, Nelson H. Kraeft, Robert N. Webster.
MADISON—None.
MANATEE—John D. Lehman, Roger A. Meyer (Absent—Irving E. Hall Jr.).
MARION—Henry L. Harrell, C. Brooks Henderson.
MONROE—Joseph L. G. Lester Jr.
NASSAU—Marshall E. Groover Jr.
OKALOOSA—William W. Thompson.
ORANGE—Norman F. Coulter, Truett H. Frazier, Eugene N. Forrester, Paul C. Harding, Franklin B. McKechnie, Louis C. Murray, Franklin G. Norris, James F. Richards Jr., Edward W. Stoner, Thomas B. Thames (Absent—Louis P. Brady).
OSCEOLA—Eugene R. Speirs.
PALM BEACH—Carl E. Andrews, Vernon B. Astler, James R. Brandon, Curtis W. Cannon, Jerry F. Cox, Dick L. Van Eldik, James R. Forlaw, Bernard Kimmel, Richard B. Moore (Absent—Willard F. Ande).
PANHANDLE—Herbert E. Brooks.
PASCO-HERNANDO-CITRUS—W. Randall Jenkins.
PINELLAS—James C. Fleming, Allyn B. Giffin, David S. Hubbell, Jack A. MaCris, William G. Mason, W. Shands McKeithen, James H. Miller Jr., Donald G. Nikolaus, David T. Overbey, Walter H. Winchester, Rowland E. Wood.
POLK—Marvin G. Burdette, Thomas M. Caswall, J. Gerard Converse, John W. Glotfelty, Robert J. Pfaff (Absent—Gordon R. Heath).
PUTNAM—(Absent—Roy E. Campbell).
ST. JOHNS—William W. O'Connell.
ST. LUCIE-OKEECHOBEE-MARTIN—Howard C. McDermid, John F. Powers.
SANTA ROSA—(Absent—William N. Watson).
SARASOTA—John N. Carlson, Samuel E. Kaplan, F. E. Pfeiffenberger, Karl R. Rolls (Absent—Millard B. White).
SEMINOLE—John T. Johnson.
SUWANNEE-HAMILTON-LAFAYETTE—Alex Kish.
TAYLOR—Frank Scarvey III.
VOLUSIA—Harry G. Gillis, Richard W. Snodgrass, Charles A. Stump (Absent—William E. Carter).
WALTON—(Absent—Howard F. Currie).
COUNCIL ON SPECIALTY MEDICINE— F. C. Andrews, Andre S. Capi, James W. Clower Jr., Jacob Green, Samuel G. Hibbs, Sanford A. Mullen, Leo C. Nickell, Robert E. Raborn, John E. Startzman, James M. Stem (Absent—Jack H. Bowen, West Bitzer, J. M. Hamilton, John R. Mahoney, E. J. Sullivan Jr., Miles W. Thomley, Richard P. Thompson).
SPEAKER OF THE HOUSE—Charles K. Donegan.
VICE SPEAKER OF THE HOUSE—Franklin J. Evans.

Upon motion duly carried, the Rules and Order of Business of the House were adopted as follows:

Information for Delegates

The Rules and Order of Business for the House of Delegates is included in this Handbook.

Delegates and alternates whose names appear in this Handbook have been certified by their county medical societies. Our By-Laws do not permit an alternate to serve for a delegate who has once been seated. The By-Laws require that delegates fill out attendance cards at each meeting of the House of Delegates in order to be credited in attendance, and further, the chairman of the Credentials Committee is required to report to the House the number of delegates who have registered their attendance cards, thus eliminating the necessity of a roll call to seat delegates.

Reports and resolutions that were received before going to press are included in this Handbook. Delegates are urged to study them carefully before they are introduced in the House. Whenever possible, it is requested that resolutions and supplemental reports be forwarded to the Association's executive office by April 25 for duplication and distribution to the delegates.

All reports and resolutions will be referred to Reference Committees by the Speaker at the First Meeting of the House of Delegates. All members who are interested in any committee report or resolution should attend the Reference Committee meetings where a full discussion will take place. Council and committee chairmen are respectfully requested to be present and discuss their respective reports. All members of Reference Committees are urged to study carefully the reports and resolutions referred to them. The chief purpose of the Reference Committees is to allow an opportunity for as many members of the Florida Medical Association as possible to appear and be heard and thus have a voice in the business of the Association. In addition, discussions before the Reference Committees have the added advantage of avoiding long discussions at the meetings of the House of Delegates. Members may request the Reference Committee chairman to defer items in which they are interested in order that they may be present to discuss the subject.

A resolution before the Reference Committee must have a sponsor present before the Reference Committee. All resolutions must be filed by 12:00 noon on the day of the First Meeting of the House of Delegates, typewritten and in proper form. The resolutions so presented will be duplicated and available at the Reference Committee meetings when they convene. Only the 'resolved' portion of resolutions will be adopted as policy. Your attention is called to the format of the annual meeting, where the Reference Committee meetings will be held in the morning following the First Meeting of the House.

We also plan to have all Reference Committee reports duplicated and available to the delegates at the Registration Desk on the morning of the day the Second House of Delegates meets in the afternoon. We trust these provisions will result in an efficient and informed House of Delegates.

All reports and resolutions included in this Handbook, as well as those which will be in the Delegates' Packets and the reports of the Reference Committees, have been color coded for easy reference. This color code is as follows:

REFERENCE COMMITTEE NO. I —Green
REFERENCE COMMITTEE NO. II —Buff
REFERENCE COMMITTEE NO. III—Blue
REFERENCE COMMITTEE NO. IV—Pink
REFERENCE COMMITTEE NO. V —Goldenrod

According to our By-Laws, nominations and seconding speeches shall be limited to a maximum of two minutes each. If additional information needs to be presented to the House, it should be duplicated and distributed to members of the House.

Your Speaker and Vice Speaker are available at any time to help in any way in the preparation of resolutions or in any capacity in which they might help any member of the Florida Medical Association.

Charles K. Donegan, Speaker
House of Delegates
Franklin J. Evans, Vice Speaker
House of Delegates

The following corrections were made in the Proceedings of the 1971 House of Delegates, as published in the July 1971 issue of the Journal of the Florida Medical Association: In the Second and Third House of Delegates' listing of seated delegates, pages 29 and 70 respectively, Collier County Medical Society Delegates Fred A. Butler and Nicholas Kalvin were to be shown as present. In the Third House under the delegates listing, page 70, Panhandle County Medical Society Delegate Herbert E. Brooks was to be shown as present. In the report of Reference Committee No. V, page 78, Resolution 71-19—Blue Shield Fee Allowances—only the Resolved portion of this resolution was to be adopted as policy, not the whereases.

A motion carried to approve the minutes of the 1971 House of Delegates as corrected.

The Speaker introduced the officers of the Association: Drs. Floyd K. Hurt, President; William J. Dean, President-Elect; James T. Cook, Immediate Past President; Ray E. Murphy Jr., Vice President; James W. Walker, Secretary and Treasurer; Franklin J. Evans, Vice Speaker of the House; and Mr. W. Harold Parham, Executive Vice President. Dr. Evans, who was unable to attend the 1971 House of Delegates meeting due to illness, expressed his appreciation for the flowers and message forwarded to him by the House.

The Speaker then instructed the House.

Remarks of the Speaker

This is your House of Delegates. We are here today representing 7,800 physicians in the State of Florida. We are the legislative and business body of the Association. We are here to make policies for the members of the Florida Medical Association for the coming year.

The House of Delegates transacts business according to a blend of rules imposed by its By-laws, established by tradition, and decreed by its presiding officer. Our By-laws state, and I quote:

> "The deliberations of the association shall be governed by parliamentary usage as contained in Sturgis Standard Code of Parliamentary Procedure, unless otherwise provided in the Charter and these By-laws, or unless waived or modified by two-thirds vote of members present at any session of the general membership or meeting of the House of Delegates."

Parliamentary law serves to aid an assembly in orderly, expeditious and equitable accomplishment of its desires. Any compulsive adherence to an inflexible set of directives may thwart rather than abet such an objective.

The majority opinion of the House in determining what it wants to do and how it wants to do it should always remain the ultimate determinant.

It is the obligation of the Speaker to sense this will of the House, to preside accordingly, and to hold his rulings ever subject to challenge from and reversal by the assemblage.

This year, as last year, there will be three sessions of the House of Delegates. This one, the second meeting on Saturday afternoon at 3 p.m. and the third meeting will be Sunday morning at 9 a.m.

Let me urge each delegate to conscientiously attend the reference committee meetings—freely express your views and opinions to the reference committees, in order that they may make sound recommendations to this House of Delegates.

Further, study the reference committee reports carefully Saturday morning, in order that we can make sound, well thought-out decisions on Saturday afternoon and Sunday.

The reference committee reports will have each line numbered in order to clarify amendments made on the floor.

Your Speaker and Vice Speaker will be available to assist you in every way possible.

Thank you.

The remarks of the Speaker of the House of Delegates were referred to Reference Committee No. III for consideration.

The Speaker announced a correction to the Delegates' Handbook. The total number of members of the House of Delegates—200—had been omitted, page 10.



Listening attentively during a session of the House of Delegates are Secretary-Treasurer James W. Walker, M.D., Jacksonville, and Past Presidents Samuel M. Day, M.D., Jacksonville, and Warren W. Quillian, M.D., Coral Gables.

The Speaker introduced distinguished guests: Mrs. Wesley S. Nock, President, and Mrs. James J. DeVito, President-Elect, Woman's Auxiliary to the Florida Medical Association; Mrs. Linus Hewit, Director and Chairman of the Health Education Committee, and Mrs. C. H. Gilliland, Southern Regional Chairman of International Health Activities, Woman's Auxiliary to the American Medical Association; and Mrs. G. Prentiss Lee, President of the Woman's Auxiliary to the AMA.

Mrs. Lee greeted the House and remarked on the potential power of the doctors' wives through utilization of their time, energy and talents. They want to do something but need direction. She reviewed the outstanding voluntary community work being done by the Woman's Auxiliary to the FMA and the effectiveness of their many fund-raising projects including their contributions to AMA-ERF. The Auxiliary and the FMA must work together, Mrs. Lee said, and use all of their resources.

President Hurt then introduced The Honorable John M. McCarty, President, The Florida Bar.

Mr. McCarty briefly commented on the "quality and quantity" of the students now being accepted into medical and law schools. He stated that with the high caliber and the overflow of students we need to expand our current thoughts to include other areas inside and outside of our practices for utilization of these individuals. Mr. McCarty closed with the challenge that "it is up to the legal profession to preserve liberty and up to the medical profession to preserve health."

Dr. Hurt recognized the following distinguished guests: Mr. Jack W. Herbert, President, Blue Shield and Blue Cross of Florida; Wilson T. Sowder, M.D., State Health Officer; and Francis P. Conroy, the Association's legal counsel.

Mr. Conroy advised that an order had been issued by the Division of Labor the previous day, May 2, implementing the revised Workmen's Compensation Fee Schedule. In outlining the details included in the revision, he said that the new schedule would become effective 45 days from the date of issuance. Mr. Conroy acknowledged the FMA Committee on Workmen's Compensation for its hard work regarding this problem. Dr. Joseph G. Matthews, Chairman of the committee, thanked those individuals involved in helping obtain this result.

Dr. Hurt requested that Dr. Eugene Peek Jr. and Dr. Brooks Henderson escort Dr. Henry Lytle Harrell to the podium, and expressed his pleasure upon presenting to Dr. Harrell the 1972 A. H. Robins Company Annual Award "For Outstanding Community Service by a Physician."



Henry L. Harrell, M.D., Ocala, receives from FMA President Floyd K. Hurt, M.D., the A.H. Robins Co. Award for Outstanding Community Service by a physician. Dr. Harrell was selected by the Board of Governors to receive the honor.

A. H. Robins Company Award

"For Outstanding Community Service By A Physician"

Henry Lytle Harrell, M.D., of Ocala, whose interest in youth extends far beyond his own children, has been elected the recipient of the 1972 A. H. Robins Company Award for community service by a Florida physician.

Each year, the Board of Governors of the Florida Medical Association faces the difficult task of selecting one member from a list of nominees submitted by county medical societies to receive the honor. Recipients are selected on the basis of distinguished service rendered to their communities.

This year's recipient is actively involved in a variety of civic and professional activities. However, the interest that is perhaps closest to his heart is in youth. As a member of the Optimist Club in Ocala, Dr. Harrell was one of the prime movers in the creation of the Marion County Boy's Club, which he has served faithfully as a vice president and director.

Dr. Harrell believes that idleness creates juvenile problems. "There's not enough for young people to do today," he remarked in a newspaper interview five years ago. "I firmly believe that work would be the biggest part of the answer for juvenile problems."

Recognizing that today's youth do not have as much opportunity for work as their parents, Dr. Harrell saw the value of the planned activities and supervision afforded by the Boy's Club.

Dr. Harrell's other civic activities include a term as President of the Optimist Club. He has been a patron of the Ocala Art Show for several years and has been a member of the Committee of One Hundred of Ocala; the Marion County Chamber of Commerce; the Board of the First Methodist Church; and the Advisory Committee to the Nursing School at Central Florida Junior College.

As active as he is in community affairs, Dr. Harrell has somehow found time to fill a role of leadership in professional and scientific activities. He once served as President of the Marion County Medical Society and

has represented that component in the House of Delegates of the Florida Medical Association for many years.

He has served as President of the Florida Academy of General Practice and as Chief of Staff of the Medic Home Nursing Center and Munroe Memorial Hospital. Dr. Harrell has been a member of the Board of Directors of the Central Florida Tuberculosis Association and was one of the original members of FMA's "Committee of Seventeen."

A Tennessean by birth, Dr. Harrell has practiced medicine in Florida since 1937 and in Ocala since 1939. He received his M.D. degree from Vanderbilt University in 1934, and during World War II, he served in the U.S. Army Medical Corps, attaining the rank of Lieutenant Colonel.

Dr. Harrell is married to the former Frances Allen, also of Tennessee, and they have six children, three boys and three girls.

Dr. Harrell: "This is another example of how good Florida has been to a Tennessee hillbilly. I want to recognize the person responsible for the whole thing, my wife, Frances. Thank you."

Dr. Hurt recognized Mr. Gene Chavoustie who was present representing the A. H. Robins Company.

Dr. Hurt introduced his wife, Veronna, and then presented his annual address. (The text of Dr. Hurt's address begins on page 21.) The Speaker referred the President's Address to Reference Committee No. III for consideration.

The Speaker announced the appointment of delegates to the Reference Committees, who had been appointed by the Speaker in consultation with the President, on the basis of five members for each Reference Committee, one from each of the four medical districts and one from the membership of the House at large. The Speaker also announced assignment of an AMA delegate as advisor to each Reference Committee, and the time and place of the meetings of the Reference Committees on Thursday, May 4:

Reference Committee No. I—Health and Education
9:30 a.m., Embassy Room
Irving M. Essrig, Chairman
William C. Ruffin Jr.
W. Dotson Wells
M. Eugene Flipse
DeWitt Daughtry
Rufus K. Broadaway, AMA Delegate Advisory

Reference Committee No. II—Public Policy
10:00 a.m., Tack Room
Allyn B. Giffin, Chairman
James B. Perry
Francis N. Cooke
Karl B. Hanson
Andre S. Capi
Richard G. Connar, AMA Delegate Advisory

Reference Committee No. III—Finance and Administration
10:30 a.m., Card Room
Richard C. Clay, Chairman
Truett H. Frazier
William W. Thompson
William W. Trice Jr.
Norman F. Coulter
Samuel M. Day, AMA Delegate Advisory

Reference Committee No. IV—Legislation and Miscellaneous
10:00 a.m., Convention Hall B
Louis C. Murray, Chairman
Daniel L. Seckinger II
William M. Straight
Charles J. Kahn
John C. Fletcher
Burns A. Dobbins Jr., AMA Delegate Advisory

Reference Committee No. V—Medical Economics
9:30 a.m., Convention Hall A
Thad Moseley, Chairman
Charles F. Tate Jr.
Robert L. Andreae
James M. Stem
Robert F. Dickey
Robert E. Zellner, AMA Delegate Advisory

AMA Delegates Reference Committee
Friday, 9:00 a.m. and 2:00 p.m., Tack Room
AMA Delegates (This meeting was scheduled for the first time this year in order that members of the Association could voice their opinions and criticisms concerning the AMA.)

The Vice Speaker, Dr. Evans, advised that if there was no objection reports and resolutions would be assigned as published in the Handbook. No objection was raised. The House's attention was called to the referrals of supplemental reports and resolutions which had been distributed in the Delegates' packets.

The Chair recognized Dr. Eugene Peek Jr. who, in the absence of Dr. Margaret Palmer, Chairman of the Committee on Archives, presented the Supplemental Report of the Committee.

Dr. Peek: "Mr. Speaker, Fellow Physicians and Guests: At this time we wish to recognize



Eugene G. Peek Jr., M.D., Ocala, had his camera with him during the Annual Meeting and apparently was looking for a picture opportunity when The Journal's photographer spotted him during a session of the House of Delegates.

those members who joined the Florida Medical Association during the years of 1944 and 1945. In honor of this event their convention badges have been differentiated by a ribbon attached to it. Would these members now please stand.

"We would now direct our thoughtful and reverent consideration to our colleagues who, during the past year, have departed this life. The name of each member appears in the Delegates' packet and a rose for each has been placed in these arrangements on the speaker's podium. Among the names is that of Dr. Orion O. Feaster who served as President of the Association in 1936. Will you please stand for a moment of silent respect:

" 'Father in Thy gracious keeping,
Leave we now Thy servant sleeping.' "
—John Ellerton

It was noted with sadness that Dr. Walter C. Payne Sr., President of the FMA in 1949, had passed away just before this House convened.

The House stood for a moment of silent commemoration of these, their colleagues.

The report of the Committee on Archives was referred to Reference Committee No. III, and the remaining reports and resolutions were referred as indicated in the packets.

The Speaker asked if there were any reports from the floor. None were presented.

The Speaker announced a film showing on the Mediterranean Adventure of the Woman's Auxiliary to the FMA immediately upon recess of the House that day; the Blue Shield Annual Meeting to be held at 8:00 a.m., Thursday, May 4; and urged delegates to attend the AMA Delegates Reference Committee at 9:00 a.m. and 2:00 p.m. on Friday, May 5.

It was also announced that the President's guest speaker for the General Session, to be held Friday, May 5, at 11:00 a.m., would be The Honorable Reubin O'D. Askew, Governor of Florida. Rep. Wilbur D. Mills, Chairman of the House Ways and Means Committee, would be the speaker at the Joint FLAMPAC and FMA Woman's Auxiliary Luncheon scheduled for 12:15 p.m., on Friday, May 5.

The House of Delegates recessed at 5:40 p.m., to reconvene on Saturday, May 6, 1972, at 3:00 p.m.



All of these men have many things in common, not the least of which is that all have served as President of the Florida Medical Association. Front row: John D. Milton, M.D., Coral Gables (1955); Ralph W. Jack, M.D., Miami (1959); Jere W. Annis, M.D., Lakeland (1958); Walter C. Jones, M.D., Miami (1941); William C. Roberts, M.D., Panama City (1957); Leo M. Wachtel, M.D., Jacksonville (1960); and James T. Cook, M.D., Marianna (1970). Back row: H. Phillip Hampton, M.D., Tampa (1965); Joseph S. Stewart, M.D., Miami (1948); Warren W. Quillian, M.D., Coral Gables (1963); W. Dean Steward, M.D., Orlando (1967); George S. Palmer, M.D., Tallahassee (1966); Samuel M. Day, M.D., Jacksonville (1964); Robert E. Zellner, M.D., Orlando (1962); Henry J. Babers Jr., M.D., Gainesville (1969): and Jack Q. Cleveland, M.D., Coral Gables (1968).

Second House of Delegates

The second meeting of the House of Delegates convened at 3:00 p.m. on Saturday, May 6, 1972, in the Regency Room of the Diplomat Hotel, Hollywood, with Dr. Charles K. Donegan, Speaker of the House, presiding.

Dr. Wood reported 179 delegates registered, constituting a quorum and it was moved that the House be seated. The motion carried.

Delegates

ALACHUA—John W. Andrews, Henry J. Babers, George A. Dell, David M. Drylie, William C. Ruffin.
BAY—James D. Nixon (Absent—W. Roland McArthur).
BREVARD—John T. Blackburn, T. John Kaminski, Paul Popovich, Joseph C. Von Thron.
BROWARD—Robert L. Andreae, Robert J. Brennan, Milton P. Caster, Richard S. Doyle, David C. Lane, J. Gordon McAllister, Ray E. Murphy, Henry D. Perry Jr., James B. Perry, Thomas F. Regan, Robert J. Steinborg, W. Dotson Wells, John I. Williams (Absent—Russell B. Carson, Joseph E. Gelety).
CHARLOTTE—Robert Palmer.
CLAY—Hinson L. Stephens.
COLLIER—Nicholas H. Kalvin (Absent—Fred A. Butler).
COLUMBIA—(Absent—Frank E. Adel).
DADE—William G. Aten, Marvin Baker, Jerome Benson, Rufus K. Broadaway, Harvey E. Brown, Manuel L. Carbonell, Richard C. Clay, Jack Q. Cleveland, Francis N. Cooke, Vincent P. Corso, DeWitt C. Daughtry, O. William Davenport, Joseph H. Davis, Richard C. Dever, Robert F. Dickey, Rudolph E. Drosd, Leon S. Eisenman, Miguel Figueroa Jr., Joseph Fitzgerald, Richard M. Fleming, M. Eugene Flipse Jr., Henry C. Hardin Jr., Marshall Hall, George Ioannides, Walter C. Jones III, John B. Liebler, Rose London, Ronald J. Mann, Charles A. Monnin Jr., Sheldon Munach, Richard Ravel, M. Murray Schechter, Robert Schiess, Daniel Seckinger, Everett Shocket, Chauncey M. Stone, Mario M. Stone, William Straight, Charles F. Tate, Maynard Taylor, Arthur W. Wood Jr., Scheffel H. Wright, Nelson Zivitz (Absent—Edward W. Cullipher).
DESOTO-HARDEE-GLADES—Calvin W. Martin.
DUVAL—Warren M. Barrett, Clyde M. Collins, Emmet F. Ferguson Jr., Karl B. Hanson, M. Harlan Johnston, Leonard E. Masters, Thad Moseley, Harry W. Reinstine Jr., John A. Rush Jr., Guy T. Selander, Albert H. Wilkinson Jr. (Absent—Thomas S. Edwards).
ESCAMBIA—Charles J. Kahn, Philip B. Phillips, Theodore J. Marshall, William M.C. Wilhoit.
FRANKLIN-GULF—Joseph P. Hendrix.
HIGHLANDS—(Absent—Donald C. Hartwell).
HILLSBOROUGH—Ernest R. Bourkard, Frank C. Coleman, Richard G. Connar, Irving M. Essrig, John C. Fletcher, Richard S. Hodes, Victor H. Knight Jr., Thomas E. McKell, William W. Trice, Henry L. Wright Jr.
INDIAN RIVER—Charles C. Flood.
LAKE—J. Basil Hall, Thomas H. Nichols.
LEE-HENDRY—Larry P. Garrett, Francis L. Howington, Edward W. Salko.
LEON-WAKULLA-JEFFERSON—Edward G. Haskell, Nelson H. Kraeft, Robert N. Webster.
MADISON—None.
MANATEE—Irving E. Hall Jr., John D. Lehman, Roger A. Meyer.
MARION—Henry L. Harrell, C. Brooks Henderson.
MONROE—Joseph L.G. Lester Jr.
NASSAU—Marshall E. Groover Jr.
OKALOOSA—William W. Thompson.
ORANGE—Norman F. Coulter, Truett H. Frazier, Eugene N. Forrester, Paul C. Harding, Franklin B. McKechnie, Louis C. Murray, Franklin G. Norris, James F. Richards Jr., Edward W. Stoner, Thomas B. Thames, Joseph J. Williams.
OSCEOLA—Eugene R. Speirs.
PALM BEACH—Willard F. Ande, Carl E. Andrews, Vernon B. Astler, James R. Brandon, Jerry F. Cox, Dick L. Van Eldik, James R. Forlaw, Bernard Kimmel, Richard B. Moore (Absent—Curtis W. Cannon).
PANHANDLE—Herbert E. Brooks.
PASCO-HERNANDO-CITRUS—W. Randall Jenkins.
PINELLAS—James C. Fleming, Allyn B. Giffin, David S. Hubbell, Jack A. MaCris, William G. Mason, W. Shands McKeithen, James H. Miller Jr., Donald G. Nikolaus, David T. Overbey, Walter H. Winchester, Rowland E. Wood.
POLK—Marvin G. Burdette, Thomas M. Caswall, J. Gerard Converse, John W. Glotfelty, Gordon R. Heath, Robert J. Pfaff.
PUTNAM—(Absent—Roy E. Campbell).
ST. JOHNS—William W. O'Connell.
ST. LUCIE-OKEECHOBEE-MARTIN—Howard C. McDermid, John F. Powers.
SANTA ROSA—(Absent—William N. Watson).
SARASOTA—John N. Carlson, Samuel E. Kaplan, F. E. Pfeiffenberger, Karl R. Rolls (Absent—Millard B. White).
SEMINOLE—(Absent—John T. Johnson).
SUWANNEE-HAMILTON-LAFAYETTE — (Absent — Alex Kish).
TAYLOR—Frank Scarvey III.
VOLUSIA—William E. Carter, Harry G. Gillis, Richard W. Snodgrass, Charles A. Stump.
WALTON—(Absent—Howard F. Currie).
COUNCIL ON SPECIALTY MEDICINE—F. C. Andrews, Andre S. Capi, James W. Clower Jr., Jacob Green, J. M. Hamilton, Samuel G. Hibbs, Sanford A. Mullen, Leo C. Nickell, John E. Startzman, James M. Stem, E. J. Sullivan, Miles W. Thomley (Absent—Jack H. Bowen, West Bitzer, John R. Mahoney, Robert E. Raborn, Richard P. Thompson).
SPEAKER OF THE HOUSE—Charles K. Donegan.
VICE SPEAKER OF THE HOUSE—Franklin J. Evans.

Dr. Hurt assumed the Chair to make presentations to the medical school deans of unrestricted contributions from the AMA-ERF. He asked the deans or their representatives to come forward to accept the checks.

Dr. Emanuel M. Papper, Dean, accepted the contribution for the University of Miami School of Medicine in the amount of $4,321. Dr. Herbert E. Kaufman, Acting Dean, accepted on behalf of Dr. Emanuel Suter, Dean, for the University of Florida College of Medicine, a check in the amount of $4,245. Dr. Charles Fishel, Associate Dean, representing Dr. Donn L. Smith, Dean,

received for the University of South Florida College of Medicine the contribution in the amount of $3,621.

Mrs. Charles H. Gilliland, Chairman of the Florida Medical Foundation Committee of the Woman's Auxiliary to the Florida Medical Association, reported on the funds raised through the efforts of the Auxiliary projects for the FMF in the past year. Donations from profits received in 1970-1971 amounted to $726.00; donations from profits received in 1971-1972 amounted to $933.60.

Report of

AMA Delegates Reference Committee

Dr. Francis T. Holland, Chairman of the AMA Delegates Reference Committee, came forward to give the report of the committee.

Dr. Holland's report was received as information.

"Mr. Speaker, Members of the House: You have no doubt noticed a large number of orange jackets worn by some here today. For many years at the AMA conventions, Florida's delegation was known by the fact that we provided orange juice through the courtesy of the Florida Citrus Commission, but it got to the point where it was prohibitive due to the fact that the hotel charged a corkage fee.

"Last year we elected Dr. Jere Annis to the Board of Trustees of the AMA to fill an unexpired term. We now plan to renominate him to a full term and, so that all AMA delegates would know the Florida delegation, especially the newer members, our alternates and officers, we decided to wear these orange jackets. By the way, we paid for them ourselves and did not even require the staff to do any leg work to procure them!

"We have heard occasional complaints in the hospital libraries and dressing rooms about the AMA. Therefore, we decided to hold a reference committee meeting of your delegates and alternates to hear all complaints. This was published in the program for this meeting. It was held yesterday at 9:00 a.m. and again at 2:00 p.m. Perhaps the purpose of this meeting may not have been made clear to you and not published soon enough. For I am sure more of you had gripes and beefs against the AMA than the four physicians who appeared before the committee.

"I hope this was not lack of interest in the AMA or American medicine. We will do this again next year and better publicize it.

"Many of you do not know that you now have an avenue to take your ideas to the AMA. If you have an idea which you would like to propose, you now have three ways to do this:

"#1. Present it to your county society and, if they approve, it is then brought to the FMA where you have the right to appear before the reference committee whether you are a delegate or not. Then, if it passes it, we carry it to the AMA and you again have the right to appear before the reference committee there and will be assisted by your delegation. Even though some of us may not agree, if it has passed the Florida House of Delegates, we support it wholeheartedly.

"#2. Take it to your specialty society and thence, through the same channels.

"#3. You may approach one of us singly, convince this delegate of a good proposal and he, as an individual, may present this at the AMA, and he will assist you in your appearance before the reference committee; however, this does not have the same force which it would have had by the other two means.

"Thus, you see, the AMA is the most democratic organization, not like the labor unions who tell their locals what they must do. The AMA is a confederation of state associations that gives guidelines to state associations but cannot force the Florida Medical Association to do anything.

"We realize that, in our state and federal governments, we do not all agree, as we have two or more political parties; however, once a decision is reached, we get behind that decision and do our best to see that it works or learn why it does not. All of our enemies are now trying to splinter us into many diverse groups so that they may divide us and conquer. Even though you may not agree wholeheartedly with the actions of the AMA (in fact, we of the Florida delegation do not always agree), but it is much better to work within an organization than to be at cross-purposes through many splinter organizations. For in union there is strength.

"I thought you might be interested in knowing how your delegation functions at the AMA. About two or three weeks prior to the convention, we receive a handbook like you have here, but which has 200 to 300 pages, which we will study prior to arriving at the convention site. There we will go over this and discuss the position that we will take and make assignments of your delegation to the various reference committees and it will be the responsibility of that individual to attend all meetings of this committee and to report to the delegation at subsequent caucuses which are usually held each morning at 7:00 a.m. throughout the session. At these sessions, before action is taken on the floor, we discuss what our position will be on the articles presented for adoption and will make an assignment as to who will speak on the floor to present our position or if any one member feels that he wishes to take opposition, he may do so. We usually agree on most items, however, we are not bound to any position unless you have dictated it here in this House of Delegates."

Report of Reference Committee No. I
Health and Education

Dr. Irving M. Essrig, Chairman of Reference Committee No. I, came forward to present the report of his committee.

Council on Scientific Activities

The Reference Committee recommended the adoption of Recommendation No. 8 of the Council after consideration of the prolonged and informative discussion of continuing education, recertification, and reexamination. The final decision, after details have been developed, must be approved by the House in 1973.

A substitute motion for Recommendation No. 8 was made "that a voluntary program for certification of achievement in continuing medical education, similar to that activated by the AMA, be developed by the Committee on Continuing Medical Education of the FMA, with guidelines and procedures for fulfilling a minimum of 30 hours a year of approved continuing medical education to achieve such certification, to be ready for presentation to the FMA House of Delegates in 1973."

The substitute motion was defeated, and the recommendation of the Reference Committee for adoption of Recommendation No. 8 was carried.

After due consideration of the data presented by the Ad Hoc Committee to Appraise the Florida Regional Medical Program, the Reference Committee recommended that the office of coordinator and president of the FRMP, Inc., be completely separated.

The recommendation was adopted.

The addendum report of the Ad Hoc Committee to Appraise the Florida Regional Medical Program had been presented to the Reference Committee verbally, in person by the entire Ad Hoc Committee. They reported that they had reviewed available data and held interviews with appropriate members and officers of the FRMP with reference to AMCEN (American Medical Communication and Electronic Network) and PRES (Program Effectiveness System for Health Care), "two organizations with minimal if any relationship to FRMP." This report, supporting data and the substance of the long discussion that followed with the Ad Hoc Committee were given due and diligent consideration.

The Ad Hoc Committee had recommended, and the Reference Committee concurred, that the report of the PRES project, which is to be completed by December 1, 1972, be widely distributed to all county societies in its totality.

The recommendation was adopted.

The Reference Committee further recommended that the approval in principle by FMA of the AMCEN project be withdrawn and withheld until such time that sufficient detailed information is made available to determine the appropriateness of endorsement by Florida medicine of this enterprise.

The recommendation was adopted.

The report of the Council on Scientific Activities was adopted.

Council on Scientific Activities

O. William Davenport, *Chairman*

Acceleration of the Association's activities in the area of continuing medical education was probably the most important development of the 1971-72 year in the Council's fields of responsibility. Also significant was a detailed, indepth appraisal of the Florida Regional Medical



Irving M. Essrig, M.D., Tampa (to right of lectern), was Chairman of Reference Committee I (Health and Education). His Committee included (left to right): DeWitt Daughtry, M.D., Miami; W. Dotson Wells, M.D., Fort Lauderdale; M. Eugene Flipse, M.D., Coral Gables; and William C. Ruffin Jr., M.D., Gainesville. Mrs. Sally Deaver served as secretary to the Committee.

Program by a special committee which reported through the Council as directed by the House of Delegates. The elevation of the Ad Hoc Committee on Liaison with Medical Students to status as a standing committee of the Council was another notable development.

Almost all matters referred to the Council during the year from various sources were considered and acted upon by the most appropriate committee before receiving final Council action. The full Council met formally on March 11, 1972, to consider the reports of each of its committees and to adopt recommendations to be submitted to the Executive Committee, Board of Governors and House of Delegates.

Each committee's activities for the year will be briefly summarized in this consolidated Council report. All recommendations adopted by the Council will be listed at the conclusion of the report. Some recommendations made to the Executive Committee and the Board of Governors will appear in the report of the latter body. The report of the Ad Hoc Committee to Appraise the Florida Regional Medical Program will be a supplement to the Council report.

The Committee on Continuing Medical Education, the name of which was changed in 1971 from "Committee on Postgraduate Education," was one of the Council's most active committees during the year, having held meetings at intervals of two to three months during the reporting period. In June, 1971, the committee sponsored an experimental pilot medical education project to demonstrate the effectiveness of a two-way audio and video closed-circuit television link between the University of Florida College of Medicine and practicing physicians in several local communities. This project was considered successful within the restrictions imposed by the physical facilities. In January, 1972, the committee sponsored a presentation on the profession's needs in continuing medical education at the Association's Annual Conference of County Medical Society Presidents and Secretaries in Orlando. During the year, the primary effort of the committee has been devoted to the development of a system for stimulating and assuring continuing education for physicians, upgrading and expanding educational programs, and establishing the Association as a state "clearinghouse" for information on this subject.

The Committee on Medical Schools completed its first year in its expanded role as the Florida Joint Commission on Medical Education. In this capacity the committee has established close liaison with the medical schools of the state to provide advice and assistance in their programs and problems and to keep abreast of new activities undertaken by the schools. The committee has concerned itself with the Community Hospital Education Council which was created in 1971 by the state legislature and plans to develop close liaison with this new state program in the interest of quality total medical education. The official status of the Joint Commission as an advisory group to the Board of Regents of the State University System has been unclear and steps are being undertaken to obtain clarification of this function.

The Committee on Medical Students began its work as the Council's newest committee by familiarizing itself with medical student liaison activities conducted by county medical societies in whose areas medical schools are located. As an initial project, the committee prepared a congratulatory letter of welcome from the President of the Association which was mailed in the summer of 1971 to each student accepted in the fall freshman class at the three Florida medical schools. The response to this letter was considered favorable. The committee has been studying various ways of communicating with medical students and receiving input from them on a regular basis. An early joint meeting with student representatives is planned for this purpose. Finally, the committee recommended to the Council that some form of Association membership for medical students be considered.

The Committee on Regional Medical Program kept the Council advised of Florida Regional Medical Program activities and served as the Association's principal liaison channel with that agency.

The Committee on Research continued its primary function of evaluating medical research project grant applications submitted to the Florida Medical Foundation. During 1971 and early 1972, five such projects were reviewed. One was approved and funded, three were disapproved and a decision is pending on the fifth as of this report.

The Committee on Scientific Assemblies began planning for the 1972 annual meeting scientific program shortly after the 1971 annual meeting. It was decided to continue the format utilized during the previous three years in which state specialty societies cosponsor, plan and produce the scientific section programs. The 1972 program as completed includes 20 scientific sections and 16 exhibits. The committee has devoted considerable effort to the problem of working more effectively with the 28 recognized specialty and subspecialty groups to develop the complete program at an earlier time each year.

The Committee on Scientific Publications completed the first year under its new name, having previously been known as the Committee on the Journal and Other Publications. The committee, headed by the editor, continued its efforts to improve the Journal as an effective scientific and informational publication for Florida physicians. Although an advertising decline in the latter part of 1971 caused a deficit in the Journal's financial statements, advertising revenue has risen markedly in early 1972 and the committee is optimistic that the publication will be able to complete the year with a favorable balance sheet while maintaining quality of content and appearance.

RECOMMENDATIONS

1. **That the report of the Ad Hoc Committee to Appraise the Florida Regional Medical Program be accepted and its recommendations be implemented.**



Paying close attention to the proceedings of the FMA House of Delegates are (left to right) AMA Past President Edward R. Annis, M.D., Miami; Robert E. Zellner, M.D., Orlando; Francis T. Holland, M.D., Tallahassee; and W. Dean Steward, M.D., Orlando.

2. That the Florida Regional Medical Program's proposal to include the FRMP Continuing Medical Education Newsletter as an insert in the Journal FMA be disapproved.
3. That the membership of the Association's standing committee on Regional Medical Program be composed largely of physicians not closely affiliated with the Florida Regional Medical Program.
4. That Resolution 70-17, "A program for aid to medical education and distribution of medical care in the state of Florida," be disapproved as submitted on the grounds that the Association does not favor "indentured" type service in repayment of medical scholarships or loans and this resolution is cumbersome and impractical; it is further recommended that the problem be kept under study for possible alternative solutions, and that the Board of Regents of the State University System be requested to compile and supply necessary data concerning need.
5. That the Association designate and send a delegate to the U.S. Pharmacopoeial Convention and that this delegate be a physician with knowledge and experience in pharmacology and clinical practice.
6. That the Association request each recognized state specialty society to appoint an annual meeting scientific program chairman two years in advance to facilitate early completion of the entire annual meeting scientific program.
7. [Filed-R.C. III]
8. That 30 hours of continuing medical education be established as a minimum requirement for maintenance of Association membership to become effective January 1, 1974, with guidelines and procedures for fulfilling this requirement to be developed by the Committee on Continuing Medical Education for presentation to the House of Delegates in 1973.
9. That local medical education programs in Florida be evaluated by the Florida Medical Association for credit toward the American Medical Association Physician's Recognition Award.
10. That the Board of Governors be requested to consider establishment of some form of association membership for medical students enrolled in Florida medical schools.

Report of Ad Hoc Committee to Appraise the Florida Regional Medical Program

Origin and Initiation of Study—Upon the recommendation of the Council on Scientific Activities, the House of Delegates in May, 1971, adopted an expression of ". . . continued concern with the direction and administration of the Florida Regional Medical Program" (hereafter referred to as "FRMP"). The House also authorized an "unbiased outside appraisal" of FRMP ". . . to evaluate its accomplishments and shortcomings" to be carried out by a committee appointed by the Board of Governors. The appraisal further was to include "any associated or related organizations such as AMCEN, PRES, ETC." The report of the committee was to be made to the Florida Medical Association through the standing Committee on Regional Medical Program and the Council on Scientific Activities.

In the latter part of the summer of 1971, the appraisal committee was appointed. In making the appointments to this five-man committee, the President and other Association officers purposely chose physicians from different areas of the state who had not previously or had only minimally been active in FRMP affairs. The committee held its first meeting in September, 1971, at which time its study plan was developed and initiated.

Methods and Implementation of Study—The study was begun with a detailed review of the history of FRMP, including the federal Heart Disease, Cancer and Stroke legislation which brought about these programs throughout the country. The committee undertook to examine (1) all funded projects initiated as well as those terminated under the program, (2) continuing medical education programs financed by FRMP at the medical schools, and (3) personnel, including policies, utilization and compensation. The committee also considered the history and function of the Association's standing Committee on Regional Medical Program.

To educate itself to its task, the committee obtained and studied annual budgets and audits of FRMP, summaries of all projects and their evaluations, fiscal data on AMCEN and PRES and job descriptions and qualifications of all FRMP personnel. From the projects funded by FRMP, several were selected for close and detailed study.

The committee went to considerable effort to obtain the candid opinions of physicians and others who had worked in and/or had special knowledge about FRMP. Each member of the committee conducted numerous interviews in person or by telephone with such individuals, both of his own choosing and as assigned by the committee. To assure a degree of uniformity and for the guidance of committee members, the committee compiled the following basic questions which were asked of all persons interviewed:

1. How successful has FRMP been in carrying out its mandate? In what ways has it been successful? In what ways unsuccessful?
2. Have funds allocated to FRMP been expended for the program's primary purpose or for administration?
3. Is FRMP duplicating existing programs, i.e., is FRMP doing jobs which relieve other organizations of their responsibilities?
4. How do you visualize the future of FRMP?
5. What will be the FMA's future involvement with FRMP?
6. Where would medical education and medical care delivery be today had there never been a RMP?

The results of all such interviews and the identities of all persons interviewed were kept entirely confidential and anonymous. Finally, the committee as a whole held lengthy interviews with the chairman of the board of directors of FRMP, Inc., the state director of FRMP, and the vice chairman of the Florida Regional Advisory Group (FRAG).

Careful review was given to the triennial application of FRMP dated November 1, 1971. Two members of the committee attended the Regional Medical Programs Service (RMPS) Site Visit to FRMP December 14-15, 1971 and were able to question and consult with members of this national out-of-state site visit team.

Observations and Conclusions—1. In the period of of its early development, FRMP encountered numerous problems, many of which stemmed from a lack of autonomy and permanent qualified staff. Among some of the unfortunate results were the funding of some ill-conceived

and poorly implemented projects without demonstrable output, the rejection of other projects with possible potential and the disproportionate support of projects in certain educational institutions. The newness of the organization, coupled with early long term projects, contributed to a delay in changing directions toward improved programs.

2. Although not an originating body for projects, FRMP has been of benefit, both financially and through the expertise of its staff and task forces, in improving many projects it has supported and in encouraging continued sustenance from other sources following termination of FRMP funding.

3. The present professional staff of FRMP is an exceptionally knowledgeable, qualified and dedicated group of individuals who have been beneficial to the recent growth and development of the program. There is some question of domination in that nominations to the task forces and FRAG may be overly influenced by the FRMP leadership and staff, thus resulting in possible "inbreeding" in these bodies.

4. The current leadership of FRMP does not agree with directives from the federal level for the program to involve itself in such new areas as peer review and promotion of health maintenance organizations (HMO's), although it is recognized that if such directives were strong enough, there would be no choice but to comply.

5. To achieve any degree of future success, FRMP will require understanding, cooperation and direction from the physicians of Florida.

RECOMMENDATIONS

1. That the Florida Medical Association continue to participate actively in and guide FRMP and all of its components, especially in helping establish priorities and directions for the entire program and its various projects.
2. That appropriate safeguards be developed and maintained to avoid duplication of effort between FRMP and the FMA, state and voluntary health agencies, and educational institutions.
3. That FRMP continue to serve as a catalyst to improve medical education and delivery, but avoid completely the actual provision of medical services.
4. That funds be sought and expended by FRMP solely on the basis of need rather than on knowledge of availability and that greater effort be made to seek advance outside advice, especially in areas in which FRMP does not possess adequate expertise within its own structure.

The committee wishes to advise that although this is its final report with respect to FRMP, it will issue a subsequent report on the American Medical Communication and Electronic Network (AMCEN) and "A Program Effectiveness System for Health Care" (PRES), two organizations with minimal if any relationship to FRMP.

The committee would like to extend its sincere appreciation to the many individuals who contributed freely of their time and experience in assisting with this study. The committee also expresses its considerable thanks to the FRMP officers and staff for willingly and promptly furnishing all information requested.

M. Murray Schechter, M.D., Chairman
Robert L. Andreae, M.D.
Frank R. Hellinger, M.D.
David S. Hubbell, M.D.
William W. Thompson, M.D.

Council on Specialty Medicine

The Reference Committee noted "it was obvious after a lengthy discussion of the report of the Council on Specialty Medicine that there were major breakdowns in communication regarding the Relative Value Studies." Upon recommendation of the Reference Committee, the House directed that the report of the Council on Specialty Medicine be filed for information.

Report of Board of Governors

Board Action No. 38
Ad Hoc Committee to Appraise the Florida Regional Medical Program

The Reference Committee recommended that Action No. 38 of the Board of Governors, concerning the Ad Hoc Committee to Appraise the Florida Regional Medical Program, be filed for information. Board Action No. 38 was filed.

(See Report of Board of Governors, page 62)

Board Action No. 41
Solicitation of Funds by Medical Schools

Upon recommendation of the Reference Committee, the House directed filing for information Action No. 41 of the Board of Governors, relative to Solicitation of Funds by Medical Schools.

(See Report of Board of Governors, page 62)

Board Action No. 52
Venomous Snake Bite

Upon recommendation of the Reference Committee, the House directed that Action No. 52 of the Board of Governors, concerning the activities of the Subcommittee on Venomous Snake Bite, be filed for information. Board Action No. 52 was filed.

(See Report of Board of Governors, page 62)

Resolution 72-14
Community Medical Education Programs
Escambia County Medical Society

The Reference Committee considered Resolution 72-14, Community Medical Education Programs, and reported that after considerable discussion, a substitute was recommended for Resolution 72-14, to be called Substitute Resolution 72-14, Community Medical Education Programs.

Substitute Resolution 72-14 was adopted.

Substitute Resolution 72-14

Community Medical Education Programs

RESOLVED, That practicing physicians and their local medical societies be encouraged to become more active and assume greater roles in medical education, be it further

RESOLVED, That local physicians and medical societies encourage and implement community medical education programs, be it further

RESOLVED, That any community medical education program must require the approval and involvement of the local medical community.

Resolution 72-31
Control of Use of Radioisotopes
Dade County Medical Association, Inc.

The Reference Committee recommended that Resolution 72-31, Control of Use of Radioisotopes, be amended by adding an additional "Resolved" at the end of the resolution. The amendment was adopted, and the resolution was adopted as amended.

Resolution 72-31

Control of Use of Radioisotopes

RESOLVED, That a new specialty board in Nuclear Medicine should not be permitted to control the use of radioisotopes to the exclusion of those who are competent in specific areas involving use of radioactivity; be it further

RESOLVED, That recognized existing medical specialty boards be allowed to develop criteria and documentation of competency in specific areas involving use of radioactivity; and be it further

RESOLVED, That copies of this resolution be distributed to the American Medical Association and the appropriate specialty boards.

Dr. Essrig: "Your Chairman wishes to thank the members of the Reference Committee, Drs. William C. Ruffin Jr., W. Dotson Wells, M. Eugene Flipse, and DeWitt Daughtry; the members of the Ad Hoc Committee, Drs. M. Murray Schechter, Robert L. Andreae, Frank R. Hellinger, David S. Hubbell, and William W. Thompson; the many members of the Association; and the secretary, Mrs. Sally Deaver, for their valuable contributions to the deliberation of your Reference Committee and for their untiring efforts in preparation of this report.

"Mr. Speaker, this concludes the report of Reference Committee No. I."



The faces of members of the Orange County (left) and Escambia County (foreground) delegations reflect one of the more serious moments of one session of the House of Delegates.

Report of Reference Committee No. II
Public Policy

The Vice Speaker, Dr. Evans, assumed the Chair and called for the report of Reference Committee No. II.

Dr. Allyn B. Giffin, Chairman, presented the report of Reference Committee No. II, Public Policy.

Council on Allied Professions and Vocations

The Reference Committee proposed the following amendments to the report of the Council on Allied Professions and Vocations.

In Recommendation 2 it was the Committee's recommendation that, following the phrase ". . . NUCLEUS OF THE COUNCIL," the remainder of Recommendation 2 be deleted as recommended by the Board of Governors. Recommendation 2 was adopted as amended.

For Recommendation 5 it was the Committee's recommendation that this recommendation be deleted in its entirety and replaced with the suggested substitute statement. The substitute statement for Recommendation 5 was adopted.

In Recommendation 6, paragraph 1, it was the Committee's recommendation that the words "twenty-four" be deleted and substituted with the word "eight" as recommended by the Board of Governors so that the registered nurse coverage would remain at eight hours as is currently required in the proposed rules for licensure of nursing homes and related facilities. Recommendation 6, paragraph 1, was adopted as amended.

It was the belief of the Committee that Recommendation 6, paragraph 2, would be too inflexible in interpretation and would also create problems in Medicare payments. It was the Committee's recommendation that Recommendation 6, paragraph 2, *not* be adopted. Recommendation 6, paragraph 2, was not adopted.

For Recommendation 8, it was the Committee's opinion that the present legislation requirement that a physician sign the death certificate solves the problem adequately. The Committee, therefore, recommended that Recommendation 8 *not* be adopted. Recommendation 8 was not adopted.

It was the Committee's recommendation, as recommended by the Board of Governors, that Recommendation 10 *not* be adopted.

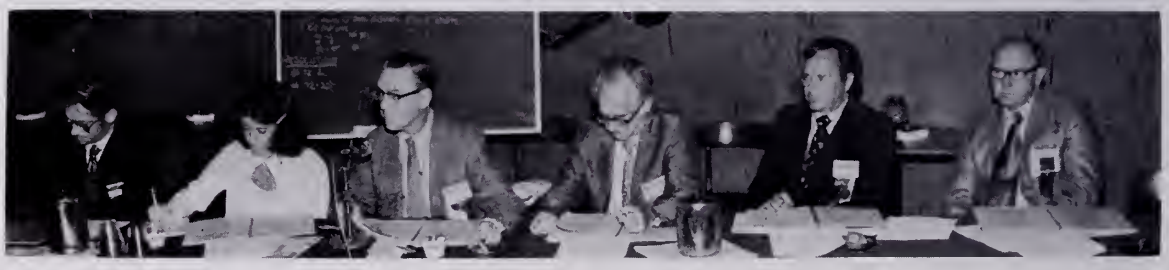
Recommendation 10 was not adopted.

For Recommendation 11, it was the Committee's recommendation that since legislation on this subject had been enacted and rendered this recommendation unnecessary, Recommendation 11 *not* be adopted.

Recommendation 11 was not adopted.

For Recommendation 12, information was received by the Committee that the American Medical Association had already approved national voluntary certification for physician's assistants and, therefore, it would be unrealistic to adopt a position of opposition. The Committee, therefore, recommended that the word "VOLUNTARY" be added so that Recommendation 12 would read:

"recommends that voluntary national certification for physician's assistants be an eventual goal . . ." with the rest of the recommendation to remain the same, and the Committee further recommended that this recommendation be adopted as amended.



Allyn B. Giffin, M.D., St. Petersburg (directly in front of chalk board) served as Chairman of Reference Committee II (Public Policy). Other Committee members were (left to right): James B. Perry, M.D., Fort Lauderdale; Karl B. Hanson, M.D., Jacksonville; Andre S. Capi, M.D., Pompano Beach; and Francis N. Cooke, M.D., Miami. Mrs. Sandy Neel recorded the proceedings.

It was adopted as amended.

It was the recommendation of the Committee that Recommendation 13 be amended to read, ". . . of the University of Florida and/or at Santa Fe Junior College" so that this recommendation would read:

"That stage one approval or procedural endorsement for programs with apparent merit which are in the planning and/or developmental phase, be granted the training program for physician's assistants of the University of Florida *and/or* at Santa Fe Junior College."

Recommendation 13 was adopted as amended.

In the second paragraph of Recommendation 16 it was the Committee's recommendation that the words "IN FAVOR OF RESEARCH" be deleted. The Committee further recommended that the last sentence be deleted and the following sentence be substituted:

It is recommended that the Board of Governors of the Florida Medical Association study this trend, and further, that our delegates to the American Medical Association express our concern about the current changes in medical education at the American Medical Association Annual Meeting.

Recommendation 16 was adopted as amended.

In Recommendation 17 the Committee recommended that the words "not favor" be deleted and the word "oppose" be substituted in its place, as recommended by the Board of Governors.

Recommendation 17 was adopted as amended.

It was the Committee's recommendation, as recommended by the Board of Governors, that Recommendation 18 *not* be adopted.

Recommendation 18 was not adopted.

In Recommendation 20 it was the Committee's recommendation that the words, "when possible" be added at the end of the sentence, as recommended by the Board of Governors.

Recommendation 20 was adopted as amended.

The report of the Council on Allied Professions and Vocations was adopted as amended.

Council on Allied Professions and Vocations

RUSSELL B. CARSON, *Chairman*

The Council held two meetings during the year, September 19, 1971, and January 28, 1972. Changing concepts in the delivery of health care and in the roles of supportive personnel were among the major issues considered by the Council. In addition to acting on recommendations of the 13 committees, the Council reviewed the health careers program conducted throughout the state by the Woman's Auxiliary. The Council offered its assistance and support in this area of activity and offered to assist the Auxiliary in planning and conducting their annual meeting of health career clubs should they so desire. The Council also endorsed a Health Careers Manual on Two Year or Less Technical Health Career Programs in the State of Florida. The manual was compiled largely through the efforts of Mrs. B. F. Brokaw of the Woman's Auxiliary and was published and distributed to junior and senior high school guidance counselors throughout the state by the Florida Health Manpower Council, Inc.

The following is a summary of the activities and recommendations of the 13 committees under the Council.

Committee on Dentistry—Liaison with the Florida Dental Association continued on an informal basis as there were no major problems requiring action. There was no formal meeting held by the committee during the year.

Committee on Dietetics—This committee continued as a one-man committee throughout the year. The chairman has continued work on development of a dietetic manual for use in small hospitals and extended care facilities. The manual is currently in field trials and will be ready for distribution within the next few months. Upon completion, the manual will be distributed by the Florida Hospital Association, Florida Dietetic Association and the Florida Medical Association. The Florida Hospital Association has agreed to house the manual and be responsible for collecting monies for selling it.

Committee on Law—Attempts to establish a medico-legal code between the two professions at the state level have been unsuccessful. New efforts in this regard will be made through the FMA Executive Committee and Board of Governors.

Many of the larger counties have a medico-legal interprofessional code which basically is a code of conduct regarding trial lawyers versus physicians on the witness stand. Other codes include a fee schedule for physicians for court appearances as expert witnesses and for depositions. Under certain circumstances, this has worked against the physician in that the trial judge sets these fees as being the maximum allowable rather than an average or minimum fee for testimony. It is the committee's opinion that guidelines should and must be developed on a state level which can be used by local medical societies as the local situation demands to form the basis for their own codes and to adjust to the needs of the local situation.

There was considerable discussion pertaining to high medical liability insurance premiums. A number of avenues of countering this continuing trend were discussed. One recommendation which seemed to merit further consideration was to reactivate and stimulate the medico-legal liaison committees at the county level for the specific purpose of actively engaging the legal profession on a personal and professional basis. For example, it was reported that one county medical society's medico-legal liaison committee held regular meetings plus a golf tournament. In that county there were eleven suits filed in one year none of which came to trial.

Committee on Medicine and Religion—The committee held one meeting during the year on April 18, 1971. The major problem facing the committee was one of educating physicians as to the purposes of the committee. A clear understanding of the total patient care concept is essential to a successful program in the state. Renewed efforts to reach physicians at the local level will be made through regional workshops throughout the state. It is hoped that this approach in lieu of one yearly statewide workshop will improve attendance. The committee's past participation in the FMA Annual Meeting scientific program and exhibits has proven that once you achieve an understanding by physicians of the need for concern for the mental as well as physical well being of the critically ill or terminal patient, a successful program is possible. The committee feels strongly that the concern of this important and complex area warrants more priority than it has received in the past.

Educational activities of the committee during the

coming year will include literary articles, seminars or workshops and hopefully an educational exhibit at the 1973 FMA Annual Meeting.

In other activities, the chairman participated in the annual AMA Regional Workshop on Medicine and Religion held February 5, 1972, in Atlanta. Participants in the workshop included representatives from the southeastern states and invited members of the clergy. The exchange of information was most helpful and stimulating. The AMA through its Department of Medicine and Religion has done much to assist states all across the country in developing successful programs.

Committee on Nursing—This committee was very active and met jointly with representatives of the Florida Nurses Association on four occasions during the year. There was a productive exchange of information at each meeting and enhanced mutual understanding between the two professions.

Much discussion centered around the expanding role of nurses in patient care including utilization of nurses as physician's assistants. There was mutual recognition that doctors need help and that the role of the nurse would expand. It was agreed that it should be left up to the individual nurse to decide whether or not she chooses to fulfill the role of a "PA" once defined and, therefore, that "PA's" not be recruited exclusively from RN's but that RN's not be excluded from becoming physician's assistants.

Following the leadership of the American Medical Association and the American Nurses Association, the committee acted jointly with the Florida Nurses Association to establish a statewide Joint Council on Nursing Practice and Education. The primary role of the Council will be to develop joint statements on nursing education and practice. The FMA Committee on Nursing and representatives of the Florida Nurses Association will serve as the nucleus of the Council which will be expanded to include representatives of the medical and nursing regulatory boards. Administrators will be invited to attend meetings when the agenda relates to them.

The committee concurred with the FNA that the Proposed Rules for Licensure of Nursing Homes and Related Facilities should require that skilled nursing care facilities provide registered nurse coverage twenty-four hours a day.

Committee on Opticians—This committee held several joint meetings during the year with the Board of Directors of the Florida Society of Ophthalmology. The problem with regard to contact lens seems to have diminished. Major concern at this time is with upgrading educational programs of the opticians.

Committee on Physical Therapy and Rehabilitation—This committee held one formal meeting during the year on October 18, 1971. In addition, representatives of the committee met jointly with the Blue Shield Claims Committee. The most pressing issue at these meetings was the matter of Blue Shield's restriction on "PT" treatments under Medicare. Because of the large number of claims and over-utilization, a limit of 20 was placed on the number of treatments allowed under Medicare without prior approval. It was the committee's feeling that this restriction was arbitrary and unequitable because of the many extenuating and different circumstances involved in each case. Pursuant to the request of the Blue Shield Claims Committee, the FMA Committee on Physical Therapy and Rehabilitation has developed and made recommendations for a more workable and equitable solution to this problem.

Committee on Physician's Assistants and Medical Assistants—This committee held one meeting during the year at which time it considered matters of major importance primarily dealing with training, certification and regulation of physician's assistants.

A special issue of *The FMA Journal* was devoted exclusively to physician's assistants. In articles contributed by several physicians, the role of this new health care provider was defined.

In considering accreditation of "PA" programs and certification of "PA's," the committee recognized that accreditation of programs should be carried out on a national basis under the purview of the American Medical Association and that the AMA should establish minimum standards for training programs. Statewide certification of physician's assistants is covered by law at the present time. The committee did, however, feel that national certification would be a desirable goal.

In other actions, the committee reviewed and made recommendations to the Council regarding the Cardiovascular Technician Training Program at the University of Florida and the Physician's Assistants Training Program at the University of Florida.

Committee on Podiatry—There were no pressing problems requiring a meeting of the committee during the year. Active liaison and discussion was continued on an informal basis. A joint article on podiatry was prepared in conjunction with the committee and the Florida Podiatry Association and published in the November 1971 issue of *The FMA Journal*. The purpose of the article was twofold. First, to set forth the advances that have been made through the cooperative efforts of the committee and the FPA to achieve better communication and understanding between the two professions. Secondly, the article was to provide the FMA membership a candid view of podiatry in the U.S. and particularly in Florida. In additional activity, the way was paved for future exchange of speakers at the FMA and FPA meetings. The committee will continue to work with FPA in areas of mutual concern.

Committee on Radiologic and Nuclear Medicine Technologists—This committee, while holding no formal meeting, has been concerned with legislation at the national level regarding the licensure of radiologic technologists. Though legislation to license radiologic technologists died during the last session of Congress, it is anticipated that legislation will be introduced during the 1972 session. The committee felt that although FMA and AMA were currently on record as being opposed to proposed federal legislation to license radiologic and nuclear medicine technologists, this position should be reiterated.

The committee reported that St. Mary's Hospital School of Radiologic Technologists in West Palm Beach now has formal affiliation with Palm Beach Junior College with a program leading to an associate science degree in radiologic technology. Graduates are certified by the American Society of Radiologic Technologists.

There were no reports of major activity received from the Committees on Medical Technologists and Pharmacy.

RECOMMENDATIONS:

(Committee on Law)

1. That when liaison between the Florida Medical Association and the Florida Bar is reestablished, renewed efforts should be made to adopt an inter-professional code along the lines of the proposed code approved by the FMA House of Delegates in 1965; and further, that concerned efforts be made by the component county medical societies to establish liaison on a quasi-professional basis and that this liaison take the form of such things as banquets and other social functions including golf tournaments with the ultimate purpose of providing a better understanding and improved relations between the two professions.

(Committee on Nursing)

2. That a statewide joint council on nursing education and practice be established. It is further recommended that the Florida Medical Association Committee on Nursing and the Medical Liaison Com-

mittee of the Florida Nurses Association serve as the nucleus of the Council.

3. It is recommended that the primary functions of a joint council on nursing education and practice be to develop joint statements on practice.

4. That the Florida Medical Association approve in principle the Florida Nurses Association's Statement on Nursing Practice relating to family planning which includes:

 (1) Nurses working in activities of conception control—professional nurses may give education and guidance relating to various methods.

 (2) Nurses participating in clinical activities of conception control, involving prescription methods—the professional nurse will have had a minimum preparation such as the Manisoff Endorsed Course for specialists in family planning.

 (3) Nurses participating in family planning activities — a certified nurse-midwife will be a recent graduate with specialized training in family planning, or will have had a refresher course in midwifery within the past two years and specialized training in family planning.

5. The Florida Medical Association recognizes the utmost importance of nursing in the provision of all types of health services to the citizens of Florida.

 The Florida Medical Association recognizes the urgency of and necessity for a close and continuing liaison with the Florida Nurses Association to resolve areas of mutual concern.

 The Florida Medical Association, through its Committee on Nursing, is not only ready but anxious to cooperate, advise, assist and consult with the Florida Nurses Association on all matters of mutual interest and/or concern.

 The Florida Medical Association and Florida Nurses Association feel it is of extreme importance to include in the criteria for functions delegated to nurses that this delegation be in the best interest of the patient.

 Although this statement is concerned only with physicians and nurses, the Florida Medical Association recognizes the need for close liaison with other allied health professions.

6. Recommends the following changes on page 7 of the "Proposed Rules, State of Florida, Department of Health and Rehabilitative Services, Division of Health, Medical and Related Fields. Chapter 100-29, Nursing Homes and Related Facilities Licensure, January 1972" wherein it states that a skilled nursing home patient is one who requires close and continual professional supervised nursing and related services in a nursing home, incident to acute illness, injury or post-hospital rehabilitation, or for long term care in serious and complicated cases of chronic nature:

 1. That the Florida Medical Association concurs with and supports the Florida Nurses Association's position that in a skilled nursing care facility, the staffing pattern should require registered nurse coverage on duty eight hours, and therefore recommends that this be included in the proposed rules for licensure of nursing homes and related facilities for 1972.

 2. [Not adopted]

7. Recommends that the legislative representatives of the Florida Nurses Associa-



Members of the Duval County delegation appeared to be all wrapped up in the business of the House of Delegates when the photographer slipped up on them. In immediate foreground is M. Harlan Johnston, M.D., Jacksonville, President of the Duval County Medical Society.

tion and Florida Medical Association maintain communication in legislative matters of mutual concern and cooperate whenever possible.

8. [Not adopted]

(Committee on Opticians)

9. Recommends the Florida Medical Association's approval of a joint resolution on opticians:

"The Florida Society of Ophthalmology commends the Florida Association of Dispensing Opticians and the Florida State Board of Dispensing Opticians in their effort to upgrade the quality of their profession.

"Further, the Florida Society of Ophthalmology offers its support and that of their members to the Florida Association of Dispensing Opticians and the Florida State Board of Dispensing Opticians in implementation of their education program."

10. [Not adopted]

11. [Not adopted]

12. Recommends that voluntary national certification for physician's assistants be an eventual goal; and further, that this is in no way intended to take away from the authority of the Florida State Board of Medical Examiners in the state's control of certification of physician's assistants.

13. That stage one approval or procedural endorsement for programs with apparent merit which are in the planning and/or developmental phase, be granted the training program for physician's assistants of the University of Florida, and/or at Santa Fe Junior College.

14. That clarification of the cardiovascular technician training program at the University of Florida has been received. It is recommended that stage two approval, which is provisional endorsement for programs with students enrolled and signifies continuing approval, be granted this program.

15. That stage two approval, which is provisional endorsement for programs with students enrolled and signifies continuing approval, be granted to the pilot study being conducted in Gilchrist County by the University of Florida College of Medicine Department of Community Health to test physician's assistants in rural areas.

16. Recommends that the Florida Medical Association reiterate the policy that training of physician's assistants not be construed as having higher priority than the training of practicing physicians.

Council is greatly concerned with the current trend to shortening medical education curriculum, the lessening amount of clinical exposure and required humanities, and the radical change in medical education at the expense of the Art of Practice. It is recommended that the Board of Governors of the Florida Medical Association study this trend, and further, that our delegates to the American Medical Association express our concern about the current changes in medical education at the American Medical Association annual meeting.

(Committee on Radiologic and Nuclear Medicine Technologists)

17. That the Florida Medical Association oppose proposed federal legislation that would license Radiologic and Nuclear Medicine Technologists.

18. [Not adopted]

19. Recommends endorsement of the Health Careers Manual on two year or less Technical Health Career Programs in the State of Florida published and distributed by the Florida Health Manpower Council, Inc. to Junior and Senior High School Guidance Counselors and further recommends that Mrs. B. F. Brokaw of the Woman's Auxiliary be commended for her efforts in compiling this manual.

20. Recommends that the appropriate FMA staff be authorized to assist the Woman's Auxiliary in planning and conducting their annual State Health Career Clubs Conference, WHEN POSSIBLE.



Edward R. Annis, M.D., Miami (center), a Past President of the American Medical Association, attended several functions during the FMA Annual Meeting. Here he is flanked by AMA Delegates Burns A. Dobbins Jr., M.D., Fort Lauderdale (left), and Robert E. Zellner, M.D., Orlando.

Council on Medical Services

It was the recommendation of the Committee that Recommendation 1 of the Council on Medical Services be deleted in its entirety and that it be replaced with a substitute recommendation. The substitute recommendation was adopted.

In Recommendation 11 (b), it was the Committee's recommendation that the words "Public

Schools" be deleted and the words "Colleges and Universities" be substituted in its place. The Committee further recommended that in Recommendation 11 (d), the words "have the right to" be deleted and the word "should" be substituted in its place.

Recommendation 11 was adopted as amended.

In Recommendation 12, the Committee recommended that the following sentence be added on to the end of this recommendation:

"That the Florida Medical Association encourage all Florida physicians to become active in improving emergency medical services in their own communities."

Recommendation 12 was adopted as amended.

Regarding Recommendation 13 it was the Committee's recommendation that since information had been received that a committee of this nature had already been established and was functioning at the present time, Recommendation 13 *not* be adopted.

Recommendation 13 was not adopted.

It was the Committee's recommendation on Recommendation 21 that, since information had been received that the program referred to had not yet been established and it would be inappropriate to request funding before the program was established, recommendation 21 *not* be adopted.

Recommendation 21 was not adopted.

It was the Committee's belief that Recommendation 23 was not workable as presented and, therefore, the Committee recommended that Recommendation 23 be referred to the Board of Governors for further study.

Recommendation 23 was referred to the Board of Governors.

The report of the Council on Medical Services was adopted as amended.

Council on Medical Services

THOMAS B. THAMES, *Chairman*

Most of the 14 committees of the Council were active during the 1971-72 year. Several are among the Association's busiest committees. One formal meeting of the Council was held February 27, 1972, to consider reports and recommendations from the individual committees, to act upon a number of matters pertinent to the entire Council, and to adopt those recommendations to be submitted in the Council's annual report.

During the reporting period, the Council and/or one or more of its committees were called upon numerous times for opinions and recommendations on a variety of subjects generally considered in the area of medical services. Most of these recommendations have appeared or will appear in reports or actions of other bodies such as the Board of Governors, the Committee on State Legislation, the State Department of Education and the State Department of Health and Rehabilitative Services and its various divisions.

This annual Council report will begin with brief summaries of several matters which concerned the entire Council or more than one of its committees. Short descriptions of the activities of each of the committees will be followed by the Council's recommendations for 1971-72.

Legislative Advice—During the 1972 session of the Florida Legislature, a record number of measures of medical interest was screened and evaluated by the Council's staff and various committees. Recommendations for establishing the Association's position on each bill were formulated and transmitted to the Capital Office and the Committee on State Legislation. The expertise of the various committees in their fields was made available at all times for consultation on legislative matters.

National Health Service Corps—This new federal medical service program, which was created by Congress under the Emergency Health Personnel Act of 1970 (P.L. 91-623), became operational early in 1972 with the assignment of medical personnel to the first areas certified in acute need of health services. Two locations in Florida, Immokalee in Collier County and Belle Glade in Palm Beach County, were among the initial group in the nation to be served under this innovative program, which requires certification of need by local and state medical societies. At the request of the Association's President, the Council developed procedures for providing FMA review and certification of community applications. As of this report, Lake Butler in Union County has been certified by the Association as an area in need, in addition to the previously mentioned Immokalee and Belle Glade, although Lake Butler's application has not yet been approved for personnel assignment at the national level. Applications from several other Florida communities are in various stages of development. The Council is keeping closely abreast of the progress of this program.

Gastrostomy Study—In February, 1972, at the request of the director of the Division of Retardation, Department of Health and Rehabilitative Services, the Association provided two physicians to serve on a nine-member outside committee which appraised the performance of gastrostomies and tube feeding at Sunland Hospital, Orlando. The Council chairman was one of the FMA representatives taking part in the study. The Council reviewed and commended the appraisal committee's final report.

Communicable Disease Conference—As authorized by the House of Delegates in 1969, a Florida Communicable Disease Conference was held March 4-5, 1972, in St. Petersburg, co-sponsored by the Association and the Division of Health. This invitational conference attended by 115 persons culminated two years of research and preparation by the Committee on Public Health and the Environment. The basic purpose of the conference was to develop "standards of practice" in Florida for the management and prevention of leading communicable diseases. The recommendations of the conference will be submitted to all appropriate bodies.

Disney World Medical Services—During this reporting period, which saw the opening of Walt Disney World near Orlando in October, 1971, the Council has been kept informed of the development and operation of medical services for this project, for which the Council chairman serves as medical director.

University of Florida Projects—The Council has maintained interest in and received reports on the progress of experimental medical care delivery projects being carried out by the University of Florida College of Medicine at Mayo in Lafayette County and at Trenton in Gilchrist County. In the former location, medical and nursing students are receiving part of their training by furnishing health care in a rural clinic situation under supervision of medical residents. In the latter, physician's assistants are being utilized in a remote location under

supervision of medical school faculty members. In each case, there are no physicians in private practice in the community.

Health Care of the Poor—The Council gave consideration to a resolution adopted by the American Medical Association House of Delegates in 1971 urging state and local medical societies to appoint a Committee on Health Care of the Poor or assign this function to an existing committee. The resolution requested such committees to maintain liaison with the AMA Committee on Health Care of the Poor. It was the Council's decision to assign this responsibility to a new subcommittee on the Committee on Public Health and the Environment.

The Committee on Aging spent major effort toward stimulating physician participation in activities leading up to and resulting from the 1971 White House Conference on Aging, which was held in Washington, D.C. November 28-December 2. The committee participated in regional and state White House Conferences and five physicians and one FMA executive staff member were appointed and served as Florida Delegates to the national conference. The committee plans to stay abreast of all developments resulting from the White House Conference. Another function of the committee has been to represent the Association on the Florida Joint Council on Health of the Aging, the membership of which has recently been expanded to 11 with the addition of the Florida Osteopathic Medical Association. It appears that the Joint Council will play a major role in the health aspects of implementation of 1971 White House Conference recommendations in the state.

The Committee on Blood was active in developing an agreement between the Florida Board of Medical Examiners and the Division of Health to monitor plasmapheresis centers. The committee is continuing its efforts to make this new agreement more effective. Another area of committee interest has been problems relating to hepatitis transmitted by blood transfusion. The committee is keeping itself informed of improved methodology for testing for hepatitis associated antigen.

The Committee on Child Health continues to be one of the Association's most active committees, meeting quarterly as School Health Medical Advisory Committee to the Florida Department of Education and the Division of Health. During the year, the committee developed recommendations on such diversified subjects as immunization standards, smoking and health, treatment of minors without parental consent, identification of learning disabilities by elementary teachers, family planning information for minors, the reorganization of child health services in the Division of Health and the provision of required physical examinations for indigent and near-indigent children.

The Committee on College Health completed its first year as the Council's newest committee. It concerned itself with a growing number of problems facing the health services of colleges and universities such as preentrance physical examinations, abortion and family planning counseling and services and the use and abuse of dangerous drugs.

The Committee on Emergency Medical Service became quite active during the year, having met formally three times. After thoroughly reviewing all activities in this field in Florida and throughout the nation, the committee developed a comprehensive program dealing with all aspects of this complex subject, including communications, transportation, quality of care, personnel training and others. The committee is working to achieve improved cooperation between the many governmental agencies at all levels with emergency health responsibilities and is attempting to upgrade quality of personnel and care through tightening of legislative standards and development of uniform training courses. The committee also is maintaining close liaison with the new Florida Regional Medical Program—Division of Health emergency medical services program.

The Committee on Hearing reviewed hearing screening problems in Florida's public schools and worked toward more adequate coverage and standardization of school hearing screening programs. The committee's long range goal is to achieve a uniform, comprehensive, state-financed program.

The Committee on Labor remained inactive but prepared to deal with any problems arising between organized labor and medicine. Following considerable discussion at its February meeting, the Council, with three dissenting votes, agreed with the committee chairman that the committee should be abolished.

The Committee on Maternal Health carried on its principal activity, the continuing statewide maternal mortality survey, and developed appropriate changes to improve its efficiency. Approximately 35 maternal deaths were reviewed and classified during the period. The committee plans to increase its reporting of survey results to attending physicians and to the profession at large. On several occasions prior to and during the 1972 legislative session, the committee was called upon for advice on proposed legislation relating to the field of obstetrics and gynecology.

The Committee on Mental Health directed its major effort during the year to the problem of drug abuse. The committee chairman served as an active member of the Association's Ad Hoc Committee on Drug Abuse and



Apparently enjoying one of the lighter moments of the House of Delegates during the FMA Annual Meeting are (left to right) Francis T. Holland, M.D., Tallahassee; Jere W. Annis, M.D., Lakeland; and W. Dean Steward, M.D., Orlando.

directs attention to the report of that committee. The Committee on Mental Health also was called upon at various times for advice in legislative matters.

The Committee on Mental Retardation met February 2, 1972, and launched a program for future activity to include investigation of the multiple needs of the retarded community at large, serving as a central source of information in this field, establishment of priorities and long range planning, and stimulating the education of physicians and other professionals in the problems of retardation. Current areas of committee interest include the reorganization of services of the Division of Retardation and indications to be included in revised state abortion laws.

The Committee on Occupational Health kept abreast of changing practices and advances in the field of occupational and industrial health.

The Committee on Public Health and the Environment reflected its expanded name in becoming actively involved in a large variety of matters. Examples included pre-marital physical examinations, bacteriological testing of swimming water, mercury residues in marine life, health hazards of pesticides, reorganization of state environmental services, serological tests for syphilis, eye prophylaxis for newborn, health care for the indigent, urine testing for dangerous drugs, screening for gonococcus, virus pollution in water, immunization programs and others. The committee planned and conducted the Florida Communicable Disease Conference held March 4-5, 1972, as mentioned in more detail earlier in this report.

The Committee on Rural Health continued to represent the Association in the joint Florida Committee on Rural Health which includes in its membership seven state agencies, farm and professional groups. The joint committee concerned itself with a number of problems affecting persons residing and working in rural areas. It also made an on-site visit in December, 1971 to the University of Florida-Lafayette County health clinic in Mayo.

The Committee on Vision kept itself informed of new developments in the eye and vision field and provided consultation and advice to groups and agencies needing such assistance.

RECOMMENDATIONS

1. That implementation of the 'Florida Implied Consent and Chemical Test Law' (Chapter 322.261, Florida Statutes), be improved by increasing the number of tests carried out by qualified personnel; and it is further recommended that provision for pre-arrest roadside breath test screening be enacted into law.
 In addition, realizing the horrible implications of increasing abuse of alcohol and drugs and their relationship to the loss of life as well as private and public property, it is recommended that the Florida Medical Association appoint appropriate councils or ad hoc committees to work with the Florida Bar Association and enforcement agencies to investigate ways and means of inhibiting offenses of this nature for the common good and general welfare of the citizens of this state.

2. That authorization be given for the establishment of a special subcommittee of the Committee on Public Health and the Environment to be responsible for problems and programs relating to health care of the poor.

3. That the "do-it-yourself" vaginal irrigation smear technique, if used at all, be limited to those women who cannot visit or be visited by a physician, nurse or specially trained technician, and that the use of such vaginal irrigation kits be opposed if other more acceptable techniques for collection of specimens are available.

4. That the Association go on record as favoring marital counseling without restriction as a matter between a patient and a physician.

5. That the Association go on record as favoring liberalization of Florida's abortion laws and opposing any legislative restriction which interferes with counseling on abortion between physician and patient.

6. That the Florida Board of Medical Examiners and the Division of Health be encouraged and requested to strengthen their joint program for surveillance of plasmapheresis centers.

7. That the Board of Governors be requested to study and put into effect an improved means of disseminating information to the membership following each state legislative session concerning new laws of concern to and affecting the medical profession.

8. That in view of alarming increases in venereal disease and illegitimate teenage pregnancies throughout Florida, the Association go on record as strongly reaffirming the need for comprehensive health education programs in the schools in grades K through 12, that appropriate measures to implement such programs be made a key part of the Association's 1973 legislative program, and that similar policies be urged for adoption by other groups such as the Florida Public Health Association, Florida Education Association and the various medical specialty societies.

9. That a pediatrician with special knowledge in kidney disease be appointed to the State Renal Disease Council and that the Department of Health and Rehabilitative Services be requested to place this medical program under professional medical administration.

10. That provision for physical examinations for indigent and near-indigent children required for school entrance be made in appropriations to the Division of Health

and County Health Departments to provide these examinations either by direct service or by contract with private physicians and dentists as appropriate and necessary in each county.

11. With respect to physical examinations for admission to state universities and junior colleges and health care for students, that:

 (a) There should be uniform requirements consistent with the state system;

 (b) Immunization standards for state colleges and universities should be met;

 (c) All universities and junior colleges not prepared to offer health care require a statement from a physician concerning health of the student, specifically asking for enumeration of any physical or emotional problems which might need identifying for the good of the student, and

 (d) Universities and junior colleges who offer students health care on a continuing basis should require complete physical examinations such as is now in effect for the state university system.

12. That the Association, through the committee on Emergency Medical Service, be authorized to obtain all possible publicity concerning the problems of providing Emergency Medical Services, with the objective of developing legislative and other governmental support for improving the situation, and that the Florida Medical Association encourage all Florida physicians to become active in improving Emergency Medical Services in their own communities.

13. [Not adopted]

14. With respect to the Florida Regional Medical Program's Plan for Emergency Medical Service for Florida 1972-75, that concern be expressed that the FRMP has no advisory committee or task force on Emergency Medical Service, and that the FMA Committee on Emergency Medical Service be made available to the FRMP and the Division of Health in an advisory capacity.

15. [Filed—R.C. No. III]

16. That a representative of the Florida Academy of Family Physicians be added as a consultant to the Committee on Maternal Health.

17. That each county medical society be requested to designate one physician to serve as a contact and consultant in his area for the Committee on Maternal Health's Maternal mortality survey.

18. That the recommendations of the special committee (chaired by Dr. John Davies) which studied the problem of mercury residues in fish be endorsed.

19. That because there is an increasing need to continue to study the long term effects of pesticides on humans in Florida, federal funds for such study be made available through continued support of the Division of Health Dade County group which has been engaged in this research.

20. That the Association strongly support the following statement from the "position of Florida Medical Association on Organization of Health and Environmental Services" which was prepared in November, 1971 by the Committee on State Legislation: It is the Association's position that health and environmental functions cannot be separated in that the protection of human health is inseparable from pollution and other environmental problems. State responsibilities and services in these areas ideally should be placed under the same government agency. It is the Association's further position that no matter what state agencies provide pollution, environmental and other health-related services, the medically oriented and directed state agency should have clear and final authority to monitor, provide advice to, suspend or otherwise alter, in the interest of protecting the human health and safety of the people of Florida, any programs or services carried out by other agencies. It is also most important that the traditional relationship with county health departments not be disturbed.

21. [Not adopted]

22. That physicians be urged to discontinue smears on females for possible presence of gonococcus and to begin taking cultures wherever practical to take advantage of new laboratory media for more rapid and accurate reporting and that the Association be requested to institute an educational program for physicians in this respect.

23. [Referred to Board of Governors]
That the Association go on record as favoring the principle of requiring the developers of retirement residential communities, particularly those located in

remote areas, to make provision for the health and medical needs of their residents.

Supplemental Report Council on Medical Services

The Reference Committee recommended that the supplemental report of the Council on Medical Services be adopted as presented.

It was adopted.

Supplemental Report Council on Medical Services

As stated in the annual report of the Council on Medical Services and as previously authorized by the House of Delegates, a Florida Communicable Disease Conference was held March 4-5, 1972, in St. Petersburg, co-sponsored by the Florida Medical Association and the Division of Health. More than 100 recommendations for reporting, management and prevention of various communicable diseases were formulated during this conference.

RECOMMENDATION

1. **It is recommended that the recommendations of the 1972 Florida Communicable Disease Conference be referred to appropriate committees of the council on medical services for study, further referral and appropriate implementation as indicated.**

Council on Voluntary Health Agencies

The Reference Committee recommended that the report of the Council on Voluntary Health Agencies be adopted as printed.

It was adopted.

Council on Voluntary Health Agencies

FRANK L. CREEL, *Chairman*

The Council held two meetings during the past year on October 1, 1971, and March 11, 1972. Both meetings included joint meetings with executive directors of the recognized voluntary health agencies. The following is a summary of the Council's major activities during 1971-1972:

Joint Statement—The Council adopted a joint statement on relationships between voluntary health agencies and governmental health programs in the same form as the statement adopted by the AMA House of Delegates, December 1, 1970.

1. Voluntary health agencies must maintain their autonomy and identity. Continued support through contributions depends upon the public's identification of these agencies with specific diseases or health problems. This identity can become obscure and autonomy restricted when the voluntary agency is substantially supported by government programs or grants.
2. The traditional innovative role in the development of health programs that has characterized the voluntary agency must be preserved. Because of the inherent restrictive factors involved in governmental operations, voluntary health agencies frequently are in a position to function more flexibly in providing service, education and research than are governmental agencies. This is one of the important differences between voluntary and governmental health activities. Voluntary agencies must maintain their dynamism and continue to develop new ideas, techniques and concepts.
3. The tax-exempt status of voluntary health agencies must not be jeopardized by their testimony on legislation before the Congress. It is the right and responsibility of these agencies to provide expert advice to the Congress.
4. Voluntary health agencies must continue their major role as underwriters of research by investigators interested in innovative approaches, exploratory projects and pilot demonstrations.
5. Voluntary health agencies must continue to guard their prerogatives and principles when they participate in programs undertaken with governmental support or funded by government. In certain instances voluntary health agencies may have an interest in government funds which are available for health programs. In such cases, effort should be made by these agencies to avoid duplication of programs or unnecessary competition for funds.
6. Voluntary agencies must assume a responsibility for evaluating government programs in health care, giving special attention to the accomplishment of stated purposes. The frequent tendency of such projects to expand and proliferate beyond their own purpose and intended objectives makes this role especially important.

Certificate— A certificate to be issued to all recognized voluntary health agencies was approved by the Council. The certificate, similar to that issued by the Indiana State Medical Association, will be issued to each recognized agency yearly and will include a list of those agencies recognized by the Florida Medical Association, a list of the criteria for recognition, and the FMA seal.

Educational Exhibit—In cooperation with the voluntary health agencies, the Council will sponsor an educational exhibit during the 1972 FMA Annual Meeting. The exhibit will be a sound-slide presentation identifying and summarizing the programs of the 12 national voluntary health agencies recognized by FMA and emphasizing Florida physician participation and involvement.

Liaison with Voluntary Agencies—Liaison has continued with the voluntary health agencies through the Florida Voluntary Health Association, the joint state coordinating body whose membership is composed of executive directors of the voluntary health agencies.

The Council participated in the 1971 Voluntary Health Institute, September 29-30, 1971, in Tampa which had as its theme "Working Together Today for Better Health Tomorrow." Major topics and discussion centered around comprehensive health planning, regional medical program, and health maintenance organizations and the effect these programs may have on voluntary health agencies.

Two joint meetings were held with executive directors of voluntary health agencies, and at both meetings there was a productive exchange of ideas and information.

Recognition Program—Pursuant to its primary purpose, the Council considered renewal of recognition for the currently recognized agencies. The criteria for recognition requires renewal each year. Agencies approved for continued recognition include:

Florida Division, American Cancer Society
United Cerebral Palsy of Florida
Easter Seal Society for Crippled Children and Adults of Florida, Inc.
Florida Heart Association, Inc.
Mental Health Association of Florida, Inc.
The National Foundation
National Multiple Sclerosis Society
Florida Society for the Prevention of Blindness, Inc.
Florida Association for Retarded Children

Florida Tuberculosis and Respiratory Disease Association
Florida Chapter, Arthritis Foundation
Florida Division, Leukemia Society of America
(A new agency was recognized, Florida Kidney Foundation, Inc.)

Southeast Regional Conference on Voluntary Health Agencies—On April 9, 1972 the FMA will co-sponsor in cooperation with the AMA Council on Voluntary Health Agencies and 12 other state medical associations a "Southeast Regional Conference on Relationships Between State Medical Associations and Voluntary Health Agencies." Other participants in the conference will include affiliates of national voluntary health agencies, state health departments, regional medical programs, comprehensive health planning agencies and others. The theme of the one-day conference will be "Voluntary Health Agencies and American Medicine" and will explore interagency cooperative efforts to improve health care services.

There will be a review of continuing professional education programs and innovative programs of the AMA Council on Voluntary Health Agencies, regional medical program, and comprehensive health planning. The effects of current and pending legislation on state medical associations and voluntary health agencies will also be considered. The chairman of the FMA Council on Voluntary Health Agencies will participate on an afternoon panel discussion on "State Medical Society Relationships with Voluntary Health Agencies."

Ad Hoc Committee on Drug Abuse

The Reference Committee considered the report of the Ad Hoc Committee on Drug Abuse.

It was the Committee's recommendation that, as recommended by the Board of Governors, Recommendation 2 of this report not be adopted.

Recommendation 2 was not adopted.

The report of the Ad Hoc Committee on Drug Abuse was adopted as amended.

Ad Hoc Committee on Drug Abuse

ROBERT P. JOHNSON, *Chairman*

The Ad Hoc Committee on Drug Abuse was created in May, 1970 by the House of Delegates and activated in November of that year with its first meeting. Since that time, this unique interdisciplinary committee has grown to a membership of 20, with three consultants from state agencies. The committee meets every five to six weeks with two-day meetings in various parts of the state. All meetings are well attended.

Represented on the committee in addition to medicine are the disciplines of education, law, law enforcement, the judiciary, the clergy and pharmacy. Also represented is the Woman's Auxiliary to the Association. The medical members are from the fields of psychiatry, pediatrics, pathology, internal medicine, preventive medicine and family practice. The consultants are from the Governor's office, the Attorney General's Office and the Drug Abuse Program of the Department of Health and Rehabilitative Services. All of these individuals give freely of their time and often personal expense for the work of the committee.

The committee has four subcommittees, each of which has carried out studies and projects in its area of responsibility. They are Education, Identification of Methadone Recipients, Management of Youthful Drug Offenders, and Physicians' Community Involvement. Summaries of some of the major activities follow.

Physician's Desk Reference on Drug Abuse—Through the assistance of the Drug Abuse Program of the Department of Health and Rehabilitative Services and the New York State Department of Health, the committee prepared a desk reference on drug abuse covering diagnosis and emergency treatment of drug overdoses, legal responsibilities of the physician, drug referral facilities, a dictionary of drug culture language, a bibliography for drug problems, and other areas. A copy of this publication was mailed to every member of the Association in February, 1972. The demand for additional copies has been so great that plans are underway to reprint this publication at an established price per copy.

School Guidelines—At the request of the Department of Education, the committee developed and prepared a series of guidelines for teachers and other school personnel for dealing with drug problems in the schools. The guidelines were accepted by the Department and circulated to all county school systems for use beginning with the 1971-72 school year.

Youthful Drug Offenders—The committee has been very concerned with the problem of the disposition and treatment of youthful drug offenders. During the summer of 1971 an extensive survey was made of the governors of the other 49 states to determine their handling of the problem. Voluminous information was received from the 46 states responding. A later survey was made of all judges with juvenile court jurisdiction in Florida, which revealed a pressing need for more adequate facilities and programs. As of this report, a more specific second survey of the juvenile judges is underway. To bring the most benefits from all of this information to Florida, the committee is working closely with the Division of Youth Services of the Department of Health and Rehabilitative Services to expand and improve that agency's progressive but limited programs. The subcommittee with this responsibility is making on-site visits to all of the facilities of the Division.

Drug Controls and Services—The Committee has concerned itself with a variety of problems and areas requiring evaluation of past practices. A recommendation was made to the Board of Governors and subsequently communicated to the Association membership that physicians be urged to limit their use of amphetamines and other stimulants to specific, recognized medical indications. The committee has worked toward some form of control on the dispensing of disposable needles and syringes and the voluntary destruction of such items by physicians when discarded. A need for ready availability of urine screening services for detection of dangerous drugs has been seen by the committee and steps are being taken in this direction. The committee supported changes in the marijuana laws which were made in 1971 and sees no need for further liberalization at this time. The committee also has continued to study the need for a triplicate narcotics prescription program for Florida.

Advisory Services—During the period of this report, the committee provided advice to the Committee on State Legislation and the Capital Office on numerous legislative measures in the drug abuse field. The chairman testified on several occasions before legislative committees. The role of the committee as an official advisory body to various state agencies has not yet been fully clarified but the committee has provided advice both upon request and on its own initiative when warranted and necessary. Special assistance has been provided to and received from the Office of the Attorney General and liaison with this state agency is considered highly worthwhile.

Role of Practicing Physician—The committee has devoted study to the important role of the private physician in dealing with drug problems in his community. To determine the attitudes of physicians on this subject, a questionnaire was mailed out early in 1972 to all Association members. The results of this survey are under analysis as of this report and will be available in the near future. County medical societies have been requested to

establish ad hoc committees on drug abuse. Further recommendations in this general area are under development.

RECOMMENDATIONS

1. That an educational program in drug abuse for counselors in training schools of the Division of Youth Services be planned and instituted jointly by the Florida Medical Association and the Department of Health and Rehabilitative Services and its appropriate divisions.
2. [Not adopted.]

Report of Board of Governors

Referral by 1971 House of Delegates National Certification of Physicians Assistants

Upon recommendation of the Reference Committee, the report of the Board of Governors on the referral by the 1971 House of Delegates, pertaining to National Certification of Physicians Assistants, was filed for information.

(See Board of Governors Report, page 58.)

Board Action No. 22 Paramedical Training Programs

Upon recommendation of the Reference Committee, Board Action No. 22, concerning Paramedical Training Programs was adopted as printed.

(See Board of Governors Report, page 61.)

Board Action No. 24 National Health Service Corps

Upon recommendation of the Reference Commitee, Board Action No. 24, regarding National Health Service Corps, was adopted as printed.

(See Board of Governors Report, page 61.)

Board Action No. 35 Florida Pediatric Society

Upon recommendation of the Reference Committee, Board Action No. 35, regarding the Florida Pediatric Society was adopted as printed.

(See Board of Governors Report, page 61.)

Board Action No. 36 Triplicate Narcotics Prescription Form

Upon recommendation of the Reference Committee, Board Action No. 36 concerning a Triplicate Narcotics Prescription Form, was filed for information.

(See Board of Governors Report, page 62.)

Board Action No. 46 Sunland Hospital

Upon recommendation of the Reference Committee, Board Action No. 46 concerning Sunland Hospital, was adopted as printed.

(See Board of Governors Report, page 62.)

Resolution 72-2 Cardio-Pulmonary Resuscitation Training for Ambulance Personnel DeSoto-Hardee-Glades County Medical Society

The Reference Committee considered Resolution 72-2, Cardio-Pulmonary Resuscitation Training for Ambulance Personnel, and was informed that legislation had been passed at the last session of the Florida Legislature that would help accomplish the intent of this resolution and further that in working through the Florida State Division of Health and the American Red Cross, the intent of this resolution could be accomplished.

The Reference Committee recommended that Resolution 72-2 not be adopted.

There was discussion, and the Reference Committee's recommendation that Resolution 72-2 not be adopted was defeated.

A motion was made that the original Resolution 72-2 be adopted.

The motion carried, and Resolution 72-2 was adopted.

Resolution 72-2

Cardio-Pulmonary Resuscitation Training for Ambulance Personnel

RESOLVED, That the Florida Medical Association introduce and actively campaign for passage of legislation requiring Cardio-Pulmonary Resuscitation training of ambulance personnel with provisions for:

1. Demonstration of competency.
2. On-going education and practice to maintain efficiency.
3. Periodic re-examinations.

Resolution 72-20 Bureau of Crippled Children Pinellas County Medical Society, Inc.

The Reference Committee recommended a substitute for Resolution No. 72-20, Bureau of Crippled Children.

Substitute Resolution 72-20, Bureau of Crippled Children, was adopted.

Substitute Resolution 72-20

Bureau of Crippled Children

RESOLVED, That a unit in state government should be established of divisional status for children's medical services.

Resolution 72-23
Physician Representation on Governmental and Voluntary Boards
Duval County Medical Society

Resolution 72-23, Physician Representation on Governmental and Voluntary Boards, was adopted as presented.

Resolution 72-23

Physician Representation on Governmental and Voluntary Boards

RESOLVED, By the Florida Medical Association, that physicians from the private sector of medicine representing the state and the local medical societies should actively seek and obtain positions on all state and local governmental and voluntary policy boards which determine the future of the community health care delivery systems within the State of Florida.

Resolution 72-26
Nomination-Nobel Prize
Bay County Medical Society

Resolution 72-26, Nomination-Nobel Prize, was adopted as presented.

Resolution 72-26

Nomination-Nobel Prize

RESOLVED, That the Florida Medical Association endorse the candidacy of Dr. Lester R. Dragstedt for the Nobel Prize in Medicine because of his achievement in PHYSIOLOGY OF THE STOMACH, as this physiology relates to peptic ulcer and to surgery for correction of this malady.

Resolution 72-28
Food and Drug Administration Drug Restrictions
Dade County Medical Association, Inc.

The Reference Committee recommended a substitute for Resolution 72-28, Food and Drug Administration Drug Restrictions.

The Substitute Resolution 72-28, Food and Drug Administration Drug Restrictions, was adopted.

Resolution 72-28

Food and Drug Administration Drug Restrictions

RESOLVED, That the Florida Medical Association ask the American Medical Association to inform the appropriate federal authorities that being over-restrictive in the development of new drugs in the long run may be disadvantageous to the health of the nation by preventing the evolution by American technology in the development and use of new drugs.

Dr. Giffin: "The chairman wishes to express his appreciation to all of the members who appeared before our Committee and to the members of the Committee who worked so diligently—Andre S. Capi, Francis N. Cooke, Karl B. Hanson and James B. Perry—and to our secretary, Mrs. Sandy Neel."

"Mr. Speaker, this concludes the report of Reference Committee No. II."

Report of Reference Committee No. III
Finance and Administration

The Speaker assumed the Chair and called for the report of Reference Committee No. III, Finance and Administration.

Dr. Richard C. Clay, Chairman of Reference Committee No. III, Finance and Administration, came forward to present the report of the Reference Committee.

Report of the Board of Governors

Under Major Activities, Presidents and Secretaries Conference, the Reference Committee recommended adoption of this recommendation.

It was adopted.

Under Nominations, the Reference Committee recommended approval of the Board of Governors nomination of John J. Cheleden, M.D., to receive the Florida Medical Association's Certificate of Merit.

It was approved and adopted.

Also under Nominations, this Reference Committee recommended approval of the Board of Governors nomination of State Senator David Campbell Lane, M.D., to receive the Certificate of Appreciation of the Florida Medical Association.

It was approved and adopted.

The Speaker made the presentations of the Certificate of Merit to Dr. John J. Cheleden, of Daytona Beach, and the Certificate of Appreciation to Dr. David Campbell Lane, State Senator, of Ft. Lauderdale.

Certificate of Merit

Dr. Cheleden: "I would like you to know I have attended every meeting put on in 22 years in Florida except one and I have never been a delegate. We had so few delegates from our small county and I knew I would always be coming. One can't help but feel emotion at such an honor —all I did was my work. I am grateful to the people who helped in this work, the members of the Judicial Council, my putting Harold Parham's blood pressure up, my county society and my wife, Mary, who understood when I was pacing the floor and mumbling to myself. Thank you for bestowing this honor upon me."

Certificate of Merit

WHEREAS, John J. Cheleden, M.D., of Daytona Beach, has rendered meritorious service to the practice of medicine and to organized medicine, particularly through the Florida Medical Association; and

WHEREAS, This esteemed colleague was born in Philadelphia, Pennsylvania, attended South Philadelphia High School for Boys, and received his Bachelor of Arts degree from Gettysburg College in Gettysburg, Pennsylvania; and

WHEREAS, He received his formal medical education at Jefferson Medical College of Philadelphia, which awarded him the degree of Doctor of Medicine in 1932; and

WHEREAS, He served an internship at Jefferson and Apprenticeship in Proctology under Dr. J. Hall Allen, and attended the Graduate School of the University of Pennsylvania; and

WHEREAS, This fine friend moved his practice from the City of Philadelphia to Ocala, Florida, in 1950, Pennsylvania's loss being Florida's gain, and thence to Daytona Beach in 1952, where he has since administered to the needs of thousands; and



Richard C. Clay, M.D., Miami (standing), was Chairman of Reference Committee III (Finance and Administration). His Committee also included (left to right): Truett H. Frazier, M.D., Orlando; William W. Trice Jr., M.D., Tampa; Norman F. Coulter, M.D., Orlando; and W. W. Thompson, M.D., Fort Walton Beach. Mrs. Mary Kay Samorisky served as recorder.

WHEREAS, His keen intellect earned for him the coveted key of Phi Beta Kappa; and

WHEREAS, The Brotherhoods of Theta Kappa Psi Medical Fraternity, Alpha Omega Alpha Honorary Medical Society and Sigma Alpha Epsilon Social Fraternity proudly claim him as one of their own; and

WHEREAS, Our beloved friend has been a member of and an asset to the Volusia County Medical Society, the Florida Medical Association, the American Medical Association, and the Southern Medical Association; and

WHEREAS, As a Diplomate of the American Board of Proctology, a Fellow of the International College of Surgery, a Fellow of the American Proctologic Society and as a Fellow of the American College of Surgeons, this dedicated servant of mankind has attained a degree of professional attainment of the highest order; and

WHEREAS, Dr. Cheleden has been a member of the Judicial Council of the Florida Medical Association since 1964, including six years as Chairman; and

WHEREAS, Many hours, days and weeks of his time have been devoted to the work of the Judicial Council; and

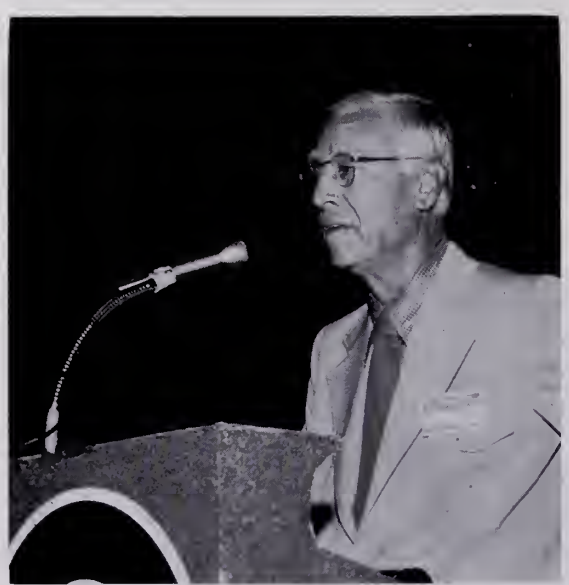
WHEREAS, This distinguished physician has made valuable and lasting contributions to the Florida Medical Association through his tireless efforts to resolve disputes, mediate conflicts and establish a high plane of ethical professional conduct; and

WHEREAS, His personal and professional conduct has always been an example for others to follow; and

WHEREAS, The title "Judge" is often applied, quite appropriately, to this purveyor of wisdom and seeker of truth; and

WHEREAS, John J. Cheleden, M.D., commands the love, respect and gratitude of the officers, members and staff of the Florida Medical Association; therefore be it

RESOLVED, That the Certificate of Merit, the Association's highest honor, be presented to this distinguished member of the Association and outstanding citizen of Florida in recognition of his unselfish service to the betterment of medicine in Florida, all to the benefit of his colleagues and the patients we serve.



"Judge" John Cheleden, M.D., Daytona Beach, longtime member and Chairman of the FMA Judicial Council, expresses his gratitude to the House of Delegates for having presented him with the Certificate of Merit, the FMA's highest honor.

Certificate of Appreciation

Dr. Lane: "I can't just accept this on my own behalf. I have had a lot of help from Scotty Fraser, Dr. Mullen and the Committee on State Legislation and certainly Dr. Hodes and other physicians in Tallahassee who have helped. It has been an exciting year. Thank you for your help for this year and for the years to come."

Certificate of Appreciation

WHEREAS, David Campbell Lane, M.D., of Fort Lauderdale has rendered outstanding and useful services to the people of Broward, Collier and Monroe Counties and Florida through his skills as an accomplished surgeon and his activities as a civic leader and a member of the Legislature of the State of Florida; and

WHEREAS, This son of the Commonwealth of Massachusetts adopted Florida as his home in 1956; and

WHEREAS, He received a Bachelor of Science Degree from the University of Tennessee, and a Doctor of Medicine Degree from the University of Tennessee College of Medicine in 1951; and

WHEREAS, Dr. Lane received internship and residency training at the University of Wisconsin Hospitals and the University of London; and

WHEREAS, His professional skills have earned for him the Diploma of the American Board of Neurological Surgeons and Fellowship or Membership in the American College of Surgeons, the International College of Surgeons, the Congress of Neurological Surgeons and the International Congress of Neurological Surgeons; and

WHEREAS, He has served with dedication and loyalty in many capacities as a member of the Broward County Medical Association, the Florida Medical Association, the American Medical Association, and the World Medical Association; and

WHEREAS, Dr. Lane has given of his time and talents to such activities as the Museum of Arts and Ft. Lauderdale Historical Society, Friends of the Library, Committee for Aid to Handicapped, United Cerebral Palsy, Young Men's Christian Association, Mental Health Association, National Rehabilitation Association, Florida Association for Retarded Children, Florida Federation of the Blind, Junior Achievement, Boy's Club and others; and

WHEREAS, These activities once led to his designation as one of the "Five Outstanding Young Men in Florida," and

WHEREAS, The people of the 36th District (Broward, Collier and Monroe Counties) in 1967, and again in 1968, expressed their confidence in Dr. Lane by electing him to the Florida Senate; and

WHEREAS, Senator Lane has gained the admiration and respect of his conservative and liberal, Republican and Democrat colleagues in the Senate; and

WHEREAS, Senate Republicans have entrusted the office of Minority Whip to Senator Lane; and

WHEREAS, Early in his Senate career he was selected as the "Most Effective Senator in Committee," and

WHEREAS, The Distinguished Senator from the 36th District has championed many causes on behalf of his people and has worked tirelessly to improve the health care delivery system in Florida; and

WHEREAS, This congenial legislator-physician has ably presented the medical point of view on legislative matters without compromising his responsibility to his constituency; and

WHEREAS, In the past this competent and compassionate surgeon has responded to requests for his skilled professional services in Tallahassee, a city far removed from his place of practice; and

WHEREAS, The members of the Florida Medical Association take great pride in having a colleague of such



FMA President Floyd K. Hurt, M.D., Jacksonville, congratulates State Sen. David C. Lane, M.D., Fort Lauderdale, to whom the House of Delegates had just awarded the Certificate of Appreciation.

outstanding abilities as a doctor, legislator and citizen; therefore be it

RESOLVED, That the Certificate of Appreciation, established in 1961 for the purpose of acknowledging exceptionally meritorious service, be awarded to State Senator David Campbell Lane, M.D., in recognition of his many contributions to the people of Florida and the profession of medicine.

Under Nominations, the Reference Committee recommended adoption of this portion of the report which set forth nominees of the Blue Shield Board of Directors.

It was adopted.

Under Committee on Membership and Discipline the Reference Committee recommended the adoption of the recommendation concerning districting for the Committee on Membership and Discipline.

It was adopted.

Under Referrals by House of Delegates, Resolution 71-4, Corporation for Physicians Negotiations, the Reference Committee recommended that this recommendation be adopted.

A motion was made from the floor that the second paragraph of the recommendation regarding Resolution 71-4, Corporation for Physicians Negotiations, be amended to read: "That the FMA organize and sponsor a corporation dedicated to the private practice of medicine in Florida; that the membership of this corporation be voluntary; and that this corporation work in close liaison with the FMA. The corporation will be known as the Florida Physicians Association, Inc."

A vote of 75:73 in favor of this amendment was received.

A recount was called for and a discussion was held for clarification of the original recommendation.

The amendment was defeated by a vote of 108:53.

A motion was made that the original recommendation regarding Resolution 71-4 be amended in the second paragraph by adding the word "private" in place of the words "fee for service system for the."

The amendment was adopted. The recommendation was adopted as amended.

Under Board Actions of Major Importance, Action No. 8, Layman's Award, the Reference Committee recommended adoption of this recommendation.

It was adopted.

Resolution 72-15

The Reference Committee considered Board Action No. 15, Liaison with Osteopathy, and Resolution No. 72-15, OSTEOPATHY LIAISON, (see page 74) together since they pertained to the same subject, and recommended that the Board of Governors recommendation and Resolution No. 72-15 be adopted.

Board Action No. 15 was adopted and Resolution No. 72-15 was adopted.

Ad Hoc Committee on Structure of FMA

A request for consideration of the report of the Ad Hoc Committee on the Structure of the FMA, regarding the Council on Specialty Medicine, before taking action on proposed by-laws amendments, was granted by the Chair.

An amendment was presented to delete the word "without" and to insert the word "with" in item 3(c) of the report of the Ad Hoc Committee on the Structure of the FMA.

A point of order was raised that an amendment which exactly reverses the intent of the original motion cannot be made.

The Chair ruled the amendment in order.

There was discussion and the Chair granted Dr. Joseph G. Matthews, chairman of the Ad Hoc Committee, the privilege of the floor. Dr. Matthews explained the detailed consideration given to this matter by the Ad Hoc Committee on the Structure of the FMA.

The amendment to the report of the Ad Hoc Committee on the Structure of the FMA was defeated.

**The report of the Ad Hoc Committee on the Structure of the FMA was adopted as presented.

Recommendations for By-Laws amendments were considered individually and adopted as presented.

The report of the Board of Governors was adopted as amended, with the exception of those portions referred to other Reference Committees.**

**(This portion of the report was considered on Sunday during the Third House of Delegates; however, it is being recorded here for continuity and clarity.)

Report of Board of Governors

FLOYD K. HURT, *Chairman*

Since the 1971 Annual Meeting, your Board of Governors has held four meetings. These were on May 9, 1971; October 7-9, 1971; January 15, 1972; and March 26, 1972. Your Executive Committee met in conjunction with each Board meeting, and because of various problems which presented themselves during intervening periods, it convened quite frequently.

The year has seen a continuation in the growth of your Association. Many problems have confronted the FMA, some of them old ones and some of them new. The Executive Committee, Board of Governors and other instrumentalities of this Association have dealt with each situation as best they knew how. It has been a year of much progress and many successes but also some disappointments.

Were it not for the dedicated men who serve on the Executive Committee and Board of Governors as well as the many Committees and Councils of the FMA, your Association could not discharge effectively its responsibilities to our member physicians and to our patients.

For the unselfish services of these fine men and women your Chairman shall be eternally grateful.

MAJOR ACTIVITIES

Annual Meeting.—The Committee on Scientific Assemblies arranged the scientific program for the 1972 Annual Meeting in cooperation with the specialty societies. The Board approved the format for the meeting and expressed the wish that the scientific program be completed much earlier this year to allow time for adequate pre-meeting publicity. However, this plan led to little success. Plans are underway for improvement.

The Board approved a change in dates for the 1975 Annual Meeting to April 23-27, 1975 (instead of April 30-May 4), at the Americana Hotel in Bal Harbour.

Presidents' and Secretaries' Conference.—One of the FMA's most helpful functions to county medical societies —the Conference of Presidents and Secretaries—was held again in Orlando on January 29. The 14th annual event featured reports on various FMA programs of importance and other topics of current interest. The following morning's Seminar on State Legislation and FLAMPAC program also proved to be a popular event. Principal speaker for the Seminar was U.S. Rep. Paul Rogers of West Palm Beach, Chairman of the House Subcommittee on Public Health and Environment and generally regarded as one of the most knowledgeable men in the Congress on health matters. Next year's Presidents' and Secretaries' Conference will be held in Orlando on January 27, 1973.

RECOMMENDATION

Your board recommends that starting in 1973, the name of the Presidents and Secretaries Conference be changed to "FMA Leadership Conference for County Medical Society Officers" and that invitations be extended to all county medical society officers.

Financial Statement and Budget.—The Board reviewed the financial statement prepared by the Executive Vice President, and approved the auditor's statement presented by the Secretary-Treasurer and prepared by Lucas, Herndon, Harms & Hyers of Jacksonville, Certified Public Accountants. This covered calendar year 1971. The Association's income from all sources was $568,064.45; expenses totaled $545,529.86, for an excess of $22,534.59 in income over expenses. These figures do not include funds expended for equipment and interest paid, since these were carried under fixed assets of the Association.

The Board approved a budget of $575,000.00 for calendar year 1972, which is the anticipated income from all sources. In accordance with the bylaws, the budget was prepared by the Executive Vice President in consultation with the Secretary-Treasurer. It was reviewed by the Executive Committee and approved by the Board of Governors.

Copies of the CPA audit are available to the appropriate Reference Committee of the House of Delegates and are on file in the Association's office for review by members of the FMA.

Appointments.— The Board of Governors named Jere W. Annis, M.D., as the AMA Delegate to serve on the Board of Governors. However, Dr. Annis later resigned as a Delegate after he was elected to the Board of Trustees of the American Medical Association, and Francis T. Holland, M.D., was elected to replace him on the Board of Governors. William M.C. Wilhoit, M.D., was named optional member of the Executive Committee.

The following physicians were named Advisory Members of the Board: Eugene G. Peek Jr., M.D., Department of Health and Rehabilitative Services; Robert E. Zellner, M.D., Blue Shield of Florida, Inc.; and Vernon B. Astler, M.D., Florida State Board of Medical Examiners. James T. Cook, M.D., Immediate Past President, was designated as FMA Public Relations Officer.

Clyde M. Collins, M.D., was appointed to his third one-year term as Editor of *The Journal of the Florida Medical Association*. The Board approved Dr. Collins' nominations of the following members of the Committee on Scientific Publications: Richard M. Fleming, M.D., Oscar W. Freeman, M.D., Willard E. Manry Jr., M.D., Thad Moseley, M.D., Franz H. Stewart, M.D. The Board also approved Dr. Collins' appointments of the following assistant editors of the Journal: Colin Kendall, M.D., Eugene L. Nagel, M.D., Gerold L. Schiebler, M.D., and William M. Straight, M.D.

Chairmen of subcommittees of the Board were appointed as follows: Rufus K. Broadaway, M.D., Inter-American Relations; Owen F. Agee, M.D., Quackery; Carl E. Andrews, M.D., Venomous Snake Bite; and Joseph G. Matthews, M.D., Workmen's Compensation.

Robert P. Johnson, M.D., was reappointed Chairman of the Ad Hoc Committee on Drug Abuse as were Karl B. Hanson, M.D., Committee on Research, and Henry R. Cooper, M.D., Joint Commission on Medical Education.

Francis T. Holland, M.D., and Burns A. Dobbins Jr., M.D., were elected Chairman and Vice Chairman, respectively, of the FMA delegation to the American Medical Association.

The Board directed that several ad hoc committees be chaired as follows: M. Murray Schechter, M.D., Ad Hoc Committee to Appraise the Florida Regional Medical Program: James L. Borland Jr., M.D., Ad Hoc Committee on Health Maintenance Organizations (Resolution 71-16);

Henry J. Babers Jr., M.D., Committee to Review the Florida Medical Insurance Trust Program; Richard J. Miller, M.D., Committee on Indian Health; Earl G. Wolf, M.D., Ad Hoc Committee to Study Resolution 71-4 (Corporations for Physicians Negotiations); and Joseph G. Matthews, M.D., FMA Committee on Structure.

RECOGNITION

The Board reviewed nominations received from county medical societies and selected therefrom the recipient of the A. H. Robins Company Award "For Outstanding Community Service by a Physician." This award will be presented at the first session of the House of Delegates on May 3, 1972. The nomination for this year's award is included in the Delegates' packets.

NOMINATIONS

The Board's nominations of physicians to receive the Certificate of Appreciation and the Certificate of Merit will be included in the Delegates' packets for presentation at the first meeting of the House of Delegates.

Judicial Council.—Under the provisions of 1971 amendments to the bylaws, the Board hereby nominates Nelson Zivitz, M.D., of Miami Beach, to succeed himself in a five-year term on the Judicial Council.

Committee on Membership and Discipline.—Under the provision of the bylaws, the Board nominates the following physicians for appointment to the Committee on Membership and Discipline for terms ending in 1976:

District 1—James T. Cook, M.D., Marianna
District 2—Alfred L. Lewis Jr., M.D., Tallahassee
District 3—John A. Rush Jr., M.D., Jacksonville
District 4—Karl T. Humes, M.D., Bushnell
District 5—Truett H. Frazier, M.D., Orlando
District 6—Ernest R. Bourkard, M.D., Tampa
District 7—John M. Butcher, M.D., Sarasota
District 8—John T. Karaphillis, M.D., Clearwater
District 9—Malcolm M. Sayre, M.D., Wauchula
District 10—Russell B. Carson, M.D., Fort Lauderdale
District 11—Nelson Zivitz, M.D., Miami Beach
District 12—Rufus K. Broadaway, M.D., Miami

RECOMMENDATION

Inasmuch as Membership and Discipline Districts are the same as Florida's Congressional Districts, and inasmuch as the State will acquire three additional Congressional Districts this year, your Board seeks the authorization of the House to fill, on an interim basis, the 12 additional membership and discipline seats (four for each district) once the Florida legislature accomplishes congressional redistricting; and further the Board requests authority to remove members of the committee at its discretion in cases in which the new redistricting plan might result in more than four members in a district as appointed under the old districting plan.

Blue Shield Board of Directors.—The Board selected nominees for election to the Blue Shield Board of Directors from a list of names submitted by the Blue Shield Nominating Committee. Two nominees for each physician seat were selected as follows:

Medical District A: James L. Borland Jr., M.D.
William M.C. Wilhoit, M.D.
Medical District B: Joseph B. Ganey, M.D.
Jack A. MaCris, M.D.
Medical District C: Andre S. Capi, M.D.
James F. Cooney, M.D.
At Large: Billy Brashear, M.D.
I. Barnett Harrison, M.D.

Lay members nominated by the Nominating Committee and approved by the Board are:

Medical District A: Ben Willis
Medical District B: John Turner
Hospital Administrator/
Blue Cross Board Member: Michael J. Wood

Florida State Board of Medical Examiners.—Notice has been taken by the Board of the three terms expiring this year on the Florida State Board of Medical Examiners. Taking into consideration recommendations by component medical societies, the Board has compiled a list of physicians which will be forwarded to Governor Reubin Askew for his consideration for appointment to the Board.

REFERRALS BY HOUSE OF DELEGATES

The 1971 Proceedings of the House of Delegates were reviewed, and items requiring study and report were referred to the appropriate committees and councils. Some matters required Board action only. Individual actions regarding the policies of the House of Delegates appear in the various council reports as well as in this report.

Resolution 71-4—Corporation for Physicians Negotiations.—This resolution was not adopted by the 1971 House of Delegates but was referred to the Board of Governors for further study. Initially, James T. Cook, M.D., Immediate Past President, was appointed to consider the intent of this resolution and report back. Pursuant to Dr. Cook's recommendation, the Board appointed an ad hoc committee. This committee submitted a report which was approved by the Board.

RECOMMENDATIONS

The Board of Governors recommends that Resolution 71-4, Corporations for Physicians Negotiations, be approved in principle and that the following recommendations be adopted in lieu of implementation of Resolution 71-4:

That the FMA organize and sponsor a corporation dedicated to the private practice of medicine in Florida; that the membership of this corporation be restricted to FMA members with voluntary participation; and that this corporation be directly responsible to the FMA. The corporation will be known as the Florida Physicians Association, Inc.

Purposes and functions:

(1) Actively pursue a program to preserve the professional and economic independence of its members.

(2) To advance, further and protect the welfare of patients and physicians in private medical practice and to preserve the integrity of their relationship.

(3) To assert the physicians' responsibility and right to assess and determine their individual roles in the practice of medicine as well as their collective interests in the establishment and maintenance of high standards of medical care in the community as a whole.

(4) To establish such organs, agencies and facilities as may be deemed necessary or desirable to represent and protect the membership as a whole and/or its individual members in transactions and/or relationships with any or all persons, parties, agencies and organizations who are third parties to the patient-physician relationship.

(5) To take advantage of existing laws that protect organized groups acting in concert.

(6) To promote the socioeconomic welfare of the physician.

(7) To protect and strengthen the patient-doctor relationship and to serve as an agent in matters involving third parties.

Resolution 71-24—Medicare Program Benefits.—Resolution 71-24 was not adopted by the House of Delegates but was referred to the Board, which in turn asked the Committee on Government Programs to study the content of the resolution and report back.

RECOMMENDATION

It is recommended by the Committee on Government Programs (concurred in by the Board) that Resolution 71-24 (Medicare Program Benefits) be adopted and implemented. (R.C. V)

Resolution 71-25—Medicare: Ostomy Irrigation Equipment.—The Board submitted to the Committee on Government Programs this resolution for study and to report back.

RECOMMENDATION

The Board recommends that the House of Delegates concur in the judgment of the Committee on Government Programs that Resolution 71-25 (Medicare: Ostomy Irrigation Equipment) not be adopted and that the FMA take no official position on this subject. (R.C. V)

Resolution 71-22—Kidney Dialysis.—(Filed-R.C. IV)

Resolution 71-2—Specialty Medicine Representation.—A new Ad Hoc Committee on the Structure of the FMA was appointed and a recommendation with respect to Resolution 71-2 is included in the report of that Committee.

1971 Recommendation No. 9, Council on Allied Professions and Vocations.—(Filed-R.C. II)

Needle and Syringe Legislation.—The House of Delegates, in 1971, referred to the Board the proposal that the FMA support legislation requiring a physician's prescription for needles and syringes. The Board has disapproved this recommendation. (Disapproved-R.C. IV)

BOARD ACTIONS OF MAJOR IMPORTANCE

1. Foundations for Medical Care.—Three Foundations for Medical Care were approved by the Board and recognized as having complied in every respect with criteria adopted by the Board of Directors of the Florida Medical Foundation. Approved Foundations, all sponsored by county medical societies, are: The Foundation for Medical Care in Duval County; the Dade County Medical Foundation, Inc.; and the Foundation for Medical Care in Escambia County. Presidents of approved Foundations for Medical Care automatically become members of the FMA Subcommittee on Foundations for Medical Care.

2. Physicians on Hospital Governing Boards.—Several months ago, Florida's Attorney General, in a formal opinion, stated that a conflict of interest is involved in cases in which a physician serves as both a member of the medical staff and on the governing board of a public hospital. With FMA's support, encouragement and assistance, two physicians serving dual roles at a hospital in Jacksonville filed suit in Duval County Circuit Court and won a favorable judgment. Your Board also offered legal and financial assistance to any other FMA member in a similar situation who wished to challenge the Attorney General's opinion.

3. Members Insurance.—Several recommendations of the Committee on Members Insurance were approved. In view of loss ratios, the Board concurred in a 30 percent increase in the catastrophe hospital plan, and a new $100,000 excess major medical insurance program was approved. Underwriting for the accidental death and dismemberment plan was transferred from the Insurance Company of North America to Continental Casualty Company as of March 1, 1972. The Committee on Members Insurance was asked to study a program of term and permanent life insurance for FMA members. (R.C. V)

4. Peer Review.—A five-point policy governing peer review activity in Florida was promulgated by the Board. It is as follows:

(1) That each component county medical society continue to perform medical utilization review activities as directed and requested by the FMA.

(2) This function may be performed at a county level through a subcommittee of the FMA.

(3) Any component county medical society which requests the state Association to perform this function for its area may advise and consult regarding the individual physicians who are appointed by the FMA to serve on this committee to perform this function as a subcommittee of the state committee.

(4) That the FMA perform this function in any area where the county medical society cannot or will not do so.

(5) The FMA shall contract with component county medical societies for administrative services when the state Association is performing peer medical utilization review for their area and it is feasible. (R.S. V)

5. Auxiliary Tours.—The FMA Woman's Auxiliary advised the Board of its plan to sponsor a medical seminar tour to the Far East to raise funds for the Florida Medical Foundation. The Auxiliary sought permission to sponsor other such tours in the future. Authorization was granted, subject to approval of individual tours by the FMA Executive Committee.

6. Peer Review Contract.—The Board authorized the Executive Vice President to sign a new contract with Blue Shield of Florida for peer review of Blue Shield and Medicare claims. It was understood that the Department of Health, Education, and Welfare would provide adequate indemnity for physicians serving on peer review committees under the Florida Medical Foundation. (R.C. V)

7. Advisory to Selective Service.—The Board concurs in the recommendation of the Council on Medical Services that the Committee on Advisory to Selective Service be removed from its jurisdiction. It is felt that the functions of this committee could be carried out more properly through the Committee on Government Programs. The Board is recommending that the bylaws be amended to accomplish this intent in the section of this report listing proposed amendments.

8. Layman's Award.—Some thought was given to establishment by the FMA of an award to recognize outstanding service by lay persons. If the House concurs in

this concept, the Board would be willing to work out details in time for a possible presentation during the 1973 Annual Meeting.

RECOMMENDATION

That an award for outstanding service by lay persons be established.

9. AMA Trustee.—The Board was pleased to note the election of Jere W. Annis, M.D., to the Board of Trustees of the American Medical Association during the AMA Annual Meeting in June, 1971. Dr. Annis was elected to the one year remaining in an unexpired term, and at the present time he is a candidate for re-election to a full three-year term, subject to balloting during the 1972 Annual Meeting of the AMA in June. The Board of Governors has gone on record as actively favoring Dr. Annis' re-election effort.

10. Indian Health.—During the year, leaders of the United Southeastern Tribes asked FMA for assistance in developing a medical service program for Florida Indians. Your Board authorized creation of an Ad Hoc Committee on Indian Affairs.

11. Caribbean Confederation of Medicine.—The Association applied for affiliate membership in the Caribbean Confederation of Medicine, and invited the President of that Confederation to attend the 1972 FMA Annual Meeting.

12. Osteopathy—Vocational Rehabilitation.—A policy was adopted for appointment to the Vocational Rehabilitation Panel. The FMA position is that such osteopaths meet the same criteria as medical doctors, namely (1) that they be board qualified or board certified by the same boards that certify doctors of medicine, and (2) that the hospitals in which their services are rendered are accredited by the Joint Commission on Accreditation of Hospitals.

13. Health Maintenance Organizations.—In conjunction with the Florida Hospital Association, FMA expressed its concern to the Department of Health, Education and Welfare, as to the disbursement of government funds for Health Maintenance Organizations and experimental delivery systems. FMA and FHA urged that private practicing physicians and hospital administrators be consulted about proposed fund allocations. (R.C. V)

14. AMA Membership and Delegates.—Florida's AMA membership of 5,020 continued to be sufficient to maintain the FMA's sixth delegate seat in the House of Delegates. This additional seat was earned last year. Your Board believes there must be a definite procedure for removing a delegate in the event the sixth seat has to be surrendered. It is the opinion of your Board that the most junior delegate in terms of length of service should be subject to removal under these circumstances, and a proposed amendment to the bylaws to accomplish this appears elsewhere in this report. Delegates seats shall be identified in the order in which they were obtained.



You could tell a Florida delegate by the color of his jacket during the Annual Meeting of the American Medical Association in San Francisco last month. These FMA notables modeled their bright orange blazers (which they bought out of their own pockets) toward the end of the Association's Annual Meeting at Hollywood in May. Front row: AMA Delegates Richard G. Connar, M.D., Tampa; Burns A. Dobbins Jr., Fort Lauderdale; and Francis T. Holland, M.D., Tallahassee; AMA Trustee Jere W. Annis, M.D., Lakeland; and AMA Delegates Robert E. Zellner, M.D., Orlando; Samuel M. Day, M.D., Jacksonville; and Rufus K. Broadaway, M.D., Miami. Second row: AMA Alternates Eugene G. Peek Jr., M.D., Ocala; Thomas B. Thames, M.D., Orlando; Francis C. Coleman, M.D., Tampa; and Jack Q. Cleveland, M.D., Coral Gables; AMA Past President Edward R. Annis, M.D., Miami; and AMA Alternate James T. Cook, M.D., Marianna. Third Row: Mr. W. Harold Parham, Jacksonville, Executive Vice President; Immediate Past President Floyd K. Hurt, M.D., and Secretary-Treasurer James W. Walker, M.D., both of Jacksonville.

15. Liaison with Osteopathy.—The matter of liaison with the osteopathy profession in Florida has been discussed in the Board of Governors, Judicial Council and the House of Delegates in the past. The Board has recently received a formal request from the Florida Osteopathic Medical Association for a liaison committee at the state level. The following recommendation was adopted by the Board at its March meeting with five dissenting votes, and these five Board members have been released from their obligation of supporting the recommendation in reference committee and/or the House of Delegates.

RECOMMENDATION

The Board of Governors recommends that its Resolution 75-15, Osteopathy Liaison, be adopted by the House of Delegates.

16. Lawsuits.—FMA's Legal Counsel has kept the Board advised of the status of pending lawsuits and potential judicial proceedings. The current standing of these matters is as follows:

(1) Sherman Anti-Trust Suit.—Defendants in this action, which was initiated by an osteopathic physician, were Jackson Memorial Hospital in Dade City, its medical staff, and the Florida Medical Association. FMA attorneys have advised that upon orders from the U.S. Circuit Court of Appeals this case has been remanded to the U.S. District Court of Tampa for dismissal, although a dismissal order has not been signed and entered as of this date.

(2) Medicaid.—Attorneys from the Florida Medical Association are continuing to study any legal remedies that might be available to the Association in challenging inequities in Florida's federally-financed Medicaid program. The level of payment for physician's services under this program has been a matter of extreme concern. Payments continue to be made at 60 percent of usual and customary fees within the 75th percentile.

Upon direction from this Board. the Executive Vice President last July petitioned the U.S. Department of Health, Education and Welfare to review this program on the basis that it seems not to comply with federal statutes requiring five basic services including physician services. In March, the Department of Health, Education and Welfare made available to the FMA a report on the Medicaid program. This report was not compiled as a result of the FMA petition but was in preparation at the time the petition was filed. It did not afford the relief sought by the Association.

(3) Sales Tax Lawsuit.—The Palm Beach County Medical Society asked the Association to enter a lawsuit as a friend of the court on behalf of a clinical laboratory to challenge a Department of Revenue ruling which apparently subjects certain laboratory items to the Florida sales tax. The Board instructed its attorney to review this case, and after the review was conducted, the Board decided not to enter the suit at this time.

(4) Phase II Wage-Price Program.—Your Board has been deeply concerned about the discriminatory feature of the Wage-Price Controls as they affect fees for medical service. The FMA President wrote a letter of protest to the Chairman of the Federal Price Commission. The Board asked the American Medical Association to institute judicial proceedings to have the controls overturned, but AMA turned down this request. The Board instructed FMA attorneys to look into the possibility of the FMA initiating such action in a federal court in Florida. However, their initial report on this was unfavorable.

(5) Reimbursement of Legal Expenses.—The Board formally asked a member to reimburse the Association for expenses incurred in the defense of an unwarranted lawsuit filed by that member against the Association.

17. New Specialty Groups.—The Florida Chapter of the American College of Emergency Physicians was approved as a recognized specialty group. Also recognized as a specialty group is the American College of Physicians, Florida Region, under the office of its Governor, provided that members of this group be required to be members of the FMA.

18. Medical Faculty Certificate.—A 1971 amendment to the Medical Practice Act makes provision for a Medical Faculty Certificate. Such a certificate permits a member of the faculty of a Florida medical school to practice medicine in conjunction with his teaching duties for a period of one year. The Board has made two judgments with respect to holders of such certificates. First, such physicians are eligible only for Associate Membership in the Florida Medical Association. Secondly, the Board has approved the Judicial Council's recommendation that these physicians be eligible to receive Blue Shield Participating Physician Numbers.

19. Health Maintenance Organizations.—Your Board is most grateful to the Ad Hoc Committee on Health Maintenance Organizations for the time and talent it expended in developing the FMA position on Health Maintenance Organizations (HMO's). (See report of Ad Hoc Committee on Health Maintenance Organizations, page 85). Your Board has concurred in the recommendation of this Committee that it be discharged and that all future matters related to HMO's, Foundations for Medical Care, experimental health delivery systems, etc., be assigned to the Board's Subcommittee on Foundations for Medical Care. (R.C. V)

20. Department of Health and Rehabilitative Services.— Formal liaison with the Florida Department of Health and Rehabilitative Services has been established through the Chairman of the Committee on Government Programs. The Association has offered to the Department and to its Divisions of Adult and Youth Corrections the services of appropriate FMA committees to evaluate medical services at institutions operated by these divisions.

21. Professional Liability Insurance.—The Board of Governors and the Employers-Commercial Union Company has reaffirmed its agreement of ten years that the program will be operated on the following basis:

(1) The program would be self-rating.

(2) Expertise would be developed through centralized claim handling, both through attorneys and Employers-Commercial Union claim department.

(3) The Company would fight all unwarranted suits.

(4) Underwriting would be handled by the company, but they would consult the Association before declining applications, canceling a policy or declining a renewal. However, the company retains the absolute right to render the final decision with respect to accepting and declining each individual application, etc.

(5) The Company would review with the Association threatened suits for opinions of a professional nature regarding the merits of the suit.

(6) The company would assist the Association with an educational program. (R.C. V)

The Association and Employers-Commercial Union also arrived at the following additional agreements:

(1) The program be continued on the basis of the understanding when the program was inaugurated.

(2) That professional liability committees be established by each county medical society where appropriate and where not appropriate, the state's committee assist with: a) Local review of underwriting individual physicians regarding their professional competence, their standing in the community, or problem with age; b) Professional review of threatened claims in the initial stages for determination from a professional standpoint of malpractice.

(3) Immediate implementation of an extensive educational program to provide the members of the Association with factual data which has been arrived at through 10 years experience under the program

of the causes of malpractice and where the premium dollars are being spent under the program.
(4) Graduates of foreign medical schools will be underwritten for a maximum of $25-75,000 unless they have completed an AMA-approved residency program in the U.S., then the company will consider additional coverage.
(5) Physicians engaged primarily in emergency room practice will be rated for underwriting in the same category as general surgeons—Classification 4.
(6) Hospital-based physicians must have ethical contracts as determined by the FMA Judicial Council. (R.C. V)

22. Paramedical Training Programs.—The Board has dispensed appropriate levels of endorsement to several training programs for paramedical personnel. Stage Two Approval (provisional endorsement for programs with students enrolled) was granted to the Cardiovascular Training Program at the University of Florida; and to the pilot study being conducted in Gilchrist County by the Department of Community Health, University of Florida College of Medicine, to test physician's assistants in rural areas. Stage One Approval (procedural endorsement for programs with apparent merit which are in the planning and/or developmental stage) was granted to the University of Florida physician assistant program at Santa Fe Junior College. (R.C. II)

23. County Medical Society Committees.—Responding to requests from the Ad Hoc Committee on Drug Abuse and the Subcommittee on Quackery, the Board has urged county medical societies to organize similar committees at the local level.

24. National Health Service Corps.—The Board directed that all requests for endorsement of assignment of National Health Service Corps physicians in Florida be referred to the Chairman of the Council on Medical Services. The Chairman's recommendation (in consultation with other FMA members) is then referred to the FMA President for action. In this manner, the Board concurred in the President's approval of the assignment of an NHSC physician in the Belle Glade, Immokalee, Lake Butler, Dixie County and Gadsden County areas. (R.C. II)

25. Committee on Advisory to Blue Shield and Fiscal Intermediaries (Committee of 17).—The Board accepted the offer of the Blue Shield Board to provide a staff member to prepare minutes and provide other assistance to the Committee of 17. The Board of Governors also authorized the distribution of abbreviated minutes of Committee of 17 meetings to practicing physicians in Florida. (R.C. V)

26. American Psychiatric Association.—The Board has recognized the Council of Florida District Branches of the American Psychiatric Association as the official representative for psychiatry on the Subcommittee of the Council of Specialty Medicine. The Council takes the place of the Florida Psychiatric Society.

27. 1971 Relative Value Studies.—The 1971 Relative Value Studies of the Florida Medical Association have been completed and copies have been mailed to all members of the Florida Medical Association. The Board directed that: the 1971 Florida RVS utilize the Current Procedure Terminology (CPT) of the American Medical Association, both the five-digit numbers and the nomenclatures; and the RVS utilize the format and modifiers of the 1969 California Medical Association RVS. Your Board gratefully acknowledges the many hours required to compile the RVS and applauds the members of the Committee on RVS for their excellent achievement. (R.C. V)

28. Conference with the Governor.—In December, the Executive Committee, the Chairmen of the Committees on State Legislation and Government Programs and FMA staff members had a 45-minute conference in Tallahassee with Governor Reubin O'D. Askew. Discussion covered: centralized medical services and professional direction and supervision of medical services; model highway evacuation and medical treatment program; activities of the FMA Ad Hoc Committee on Drug Abuse; the professional liability problem in Florida; the budget of the Florida State Board of Medical Examiners; means of communication between FMA and the Governor; and the workmen's compensation program.

Governor Askew indicated that he preferred not to have an FMA advisory committee on health. He suggested that one physician be assigned to handle liaison between the FMA and his office. This assignment was given to William M.C. Wilhoit, M.D., a member of the Executive Committee.

29. Contract with Regional Medical Program.—The Board approved the offer of the Florida Regional Medical Program to contract with the Florida Medical Foundation for a study of the role of contract practice, HMO's, HSO's, and Foundations for Medical Care. The one-year, $25,000 contract will entail review of the 1972 Florida HMO enactment with assessment of its applicability in Florida; identification of population entities and geographical areas which might be served by contract medicine; review of the health manpower situation in Florida and the increase of medical personnel in areas where services and facilities are limited; assemble data on the cost of providing comprehensive services through contract medicine; review Florida applications for HMO grants; and examination of the role of Florida's medical schools and teaching hospitals in contract practice.

30. Advisory Committee to Selective Service.—The Council on Medical Services has recommended, and the Board is in agreement, that the Advisory Committee to Selective Service be abolished. It is suggested that an additional member be added to the Committee on Government Programs to handle this function, and a proposed amendment to the bylaws to accomplish this change appears elsewhere in this report.

31. President's Commission on PLI.—The President's Commission on Professional Liability Insurance held a hearing in New Orleans, La., January 28-29. Samuel M. Day, M.D., a Past President of FMA, was designated to make a presentation on behalf of the Association.

32. FMA Medical Districts.—The Board reviewed the physician population in each of FMA's four medical districts and concluded that population shifts are not of sufficient magnitude to warrant redistricting. The membership status in each district is as follows:

	Membership		
District	Jan. 1971	Jan. 1972	Variation
A (North)	1,326	1,458	+132
B (West)	1,743	1,881	+138
C (East)	1,957	2,152	+195
D (South)	2,143	2,140	— 3

33. V.A. Physician Membership.—The Board has given attention to a problem that was brought about when Veterans Administration physicians and interns and residents became no longer eligible for special associate membership in the American Medical Association. These are in the "associate" category in the Florida Medical Association. The Board urges county medical societies to encourage their licensed V.A. members to apply for active membership and to encourage their unlicensed V.A. members to seek Florida licensure so that they will be eligible for active membership. Special active classifications for V.A. physicians and interns and residents are not proposed.

34. Science Fair Awards.—The Board has approved discontinuance of FMA Annual Science Fair Exhibit Award support beyond current commitments.

35. Florida Pediatric Society.—During the year, the legislative program of the Florida Pediatric Society appeared to deviate from that of the FMA. The Executive Committees of the Pediatric Society and the FMA met

in January to discuss these differences. The Board has approved the recommendations of the Executive Committee in this regard. The FMA supports the Pediatric Society's legislation to elevate the organizational status of the Bureau of Crippled Children to the Division of Crippled Children.

The Board also declared the following policy: if a separate Department of Health is not created, approval is given to a plan whereby the existing Bureau of Maternal and Child Health would be divided into two separate bureaus. (R.C. II)

36. Triplicate Narcotics Prescription Form.—The Ad Hoc Committee on Drug Abuse has persistently recommended that FMA endorse a triplicate prescription form program for Schedule II Narcotics similar to a program in California. The Board has disapproved the recommendation of the Committee. (R.C. II)

37. Resolution 72-1—Health Insurance Coverage for Newborn Infants.—The Florida Medical Association is opposed to any legislation which would require health insurance companies to provide specific coverages to their policy holders. The intent of Resolution 72-1 (Health Insurance Coverage for Newborn Infants) is to require coverage of all newborn infants in health insurance policies in Florida. The Florida Legislature recently passed legislation embodying this concept. (R.C. V recommendation not adopted)

38. Ad Hoc Committee to Appraise the Florida Regional Medical Program.—[Filed-R.C. I]

39. Policy Manual.—In the past, FMA has published a Policy Manual for Council and Committee Chairmen. In recent years this manual has not been distributed, but republication was authorized.

40. Interns and Residents—Blue Shield.—The Board of Governors has made a determination that "moonlighting" interns and resident physicians should not be eligible to receive Blue Shield Participating Physician Numbers. This judgment conforms to present Blue Shield policy. (R.C. V)

41. Solicitations of Funds by Medical Schools.—[Filed-R.C. I]

44. Coral Springs Project.—The Board received a report of the implementation of the medical services delivery system from the University of Miami/Westinghouse Coral Springs Health Center.

45. FIRP Committee.—The Board of Governors deactivated the Subcommittee on Florida Individual Responsibility Programs as there has been no activity of this committee in recent years. (R.C. V)

46. Sunland Hospital.—The Board of Governors received a report on the result of the investigation of gastrostomies at the Sunland Training Center in Orlando in which study FMA representatives participated. (R.C. II)

47. Historical Marker.—The Board authorized completion of arrangements to place a historical plaque on a building in downtown Jacksonville owned by the Benevolent and Protective Order of Elks. The building stands at the site of the founding of the Florida Medical Association almost 100 years ago.

48. FMA Headquarters.—The Board of Governors reviewed a report of the Executive Committee which recommended that the FMA remain in Jacksonville although due to condemnation of a portion of the Association's property it may be necessary to relocate in Jacksonville and directed that the Executive Vice President's memo regarding this be attached to the resolution in the Handbook.

49. FMA Investment Plan.—The Board of Governors reviewed and approved recommendations of the FMA Investment Plan Committee for modifications in the Investment Plan. (R.C. V)

50. AMA Delegates.—The Board of Governors reviewed the annual report of the FMA Delegates to the AMA and recommended that it be transmitted to the House of Delegates.

51. Florida Medical Foundation.—The Board of Governors and the Board of Directors of the Florida Medical Foundation authorized activities of employment of full time staff for the Foundation to administer the Peer Medical Utilization Review Contract, the agreement to study contract practices of medicine, and to coordinate the activities of the current Foundations for Medical Care in Florida.

52. Venomous Snake Bite.—[Filed-R.C. I]

53. Workmen's Compensation.—[Filed-R.C. V]

RECOMMENDATIONS

(Bylaws Amendments)

After careful consideration of proposed amendments to the FMA Bylaws, the Board of Governors submits the following recommendations for amendments:

CHAPTER IV—HOUSE OF DELEGATES, Section 6, Determination of Delegates

Amend the second paragraph of Section 6 by DELETING THE SENTENCE: "In addition to the delegates from the county medical societies, the members of the council on specialty medicine shall be members of the House of Delegates."

Section 14, Privilege of the Floor

Amend to read:

"The privilege of the floor shall be restricted to seated delegates, officers, members of the Board of Governors, AMA Delegates, Past Presidents, MEMBERS OF THE COUNCIL ON SPECIALTY MEDICINE, and AMA past presidents who are FMA members, except by permission of the presiding officer.

"THIS PRIVILEGE INCLUDES THE RIGHT TO MAKE MOTIONS, PROVIDED THEY ARE SECONDED BY A VOTING MEMBER OF THE HOUSE."

CHAPTER VI—OFFICERS AND DELEGATES TO AMA, Section 4, Vice President

Amend Section 4 by adding another sentence to read:

"HE SHALL BE A FULL MEMBER OF THE BOARD OF GOVERNORS AND THE EXECUTIVE COMMITTEE WITH THE RIGHT TO VOTE."

Section 10, Removal from Office and Appointment to Fill Vacancy

Amend by adding an additional paragraph to this section to read:

"IN THE EVENT OF THE NECESSITY TO REDUCE THE NUMBER OF DELEGATES TO THE AMA DUE TO THE LOSS OF A SEAT IN THE HOUSE OF DELEGATES OF THE AMA, THE SENIORITY OF THE INDIVIDUAL DELEGATES IN TERMS OF LENGTH OF SERVICE AS AN AMA DELEGATE SHALL DETERMINE WHICH OF THE AMA DELEGATES SHALL BE REMOVED, AND THE MOST JUNIOR DELEGATE ACCORDING TO THIS SENIORITY SHALL BE REMOVED. AMA DELEGATE SEATS SHALL BE IDENTIFIED BY NUMBER IN THE ORDER IN WHICH THEY WERE OBTAINED."

CHAPTER VII—BOARD OF GOVERNORS, Section 2, Duties and Functions

Amend by adding an additional item, #9, to read:

"9. THE BOARD OF GOVERNORS SHALL DIRECT AND SUPERVISE THE ACTIVITIES OF THE ASSOCIATION PERTAINING TO ALL FORMS OF INSURANCE AFFECTING THE MEMBERSHIP, INCLUDING PROFESSIONAL LIABILITY, DISABILITY, GROUP LIFE AND DEFERRED INCOME INSURANCE. THE BOARD MAY AT ITS DISCRETION APPOINT SPECIAL COMMITTEES TO ASSIST IN THIS ACTIVITY AS DEEMED ADVISABLE."

Section 6, Executive Committee

Amend Item 1, Composition, of Section 6 to read:

"1. Composition.—The Executive Committee of the Board of Governors shall consist of the President, President-Elect, VICE PRESIDENT, Secretary, Immediate Past President, and an optional member who may be appointed by the President with the approval of the Board."

CHAPTER VIII—COUNCILS, Section 3, Duties and Functions

Amend Item No. 3, The Council on Medical Economics, by DELETING THE PHRASE ". . . shall direct and supervise the activities of the Association pertaining to all forms of insurance affecting the membership including professional liability, disability, group life and deferred income insurance." (The remainder of the paragraph would remain unchanged.)

Amend Item No. 7 to read:

"7. THE COUNCIL ON SPECIALTY MEDICINE SHALL PROVIDE REPRESENTATION OF ALL SPECIALTY ORGANIZATIONS WITHIN THE FMA AND SHALL MAINTAIN LIAISON WITH AND SERVE IN AN ADVISORY CAPACITY TO ALL RECOGNIZED SPECIALTY GROUPS AND THE BOARD OF GOVERNORS OF FMA. IT SHALL CONSIDER ALL MATTERS REFERRED TO IT BY THE HOUSE OF DELEGATES, BOARD OF GOVERNORS, EXECUTIVE COMMITTEE, OR PRESIDENT OF FMA, AND SHALL PROVIDE HARMONY AND COHESIVENESS TO THE GENERAL BODY OF MEDICINE IN FLORIDA. IT SHALL REPORT ITS ACTIVITIES REGULARLY TO THE BOARD OF GOVERNORS."

CHAPTER IX—COMMITTEES, Section 1, Organization

Amend the paragraph for The Council on Medical Economics by DELETING THE WORDS "Members Insurance," and "Professional Liability Insurance."

Amend the paragraph for The Council on Medical Services by DELETING THE WORDS "Advisory to Selective Service" and "Labor."

Amend the paragraph for the Council on Specialty Medicine to read:

"THE COUNCIL ON SPECIALTY MEDICINE: THE COUNCIL ON SPECIALTY MEDICINE



There was a smile on every man's face as the new Board of Governors got together to begin FMA's 1972-73 business year. Front row: John C. Fletcher, M.D., Tampa, Vice President; Joseph C. Von Thron, M.D., Cocoa Beach, President Elect; William J. Dean, M.D., St. Petersburg, President; Floyd K. Hurt, M.D., Jacksonville, Immediate Past President; James T. Cook, M.D., Marianna, Past President; James W. Walker, M.D., Jacksonville, Secretary-Treasurer; and Franklin J. Evans, M.D., Coral Gables, Speaker of the House of Delegates. Back row: Eugene G. Peek Jr., M.D., Ocala, Department of Health and Rehabilitative Services; Vernon B. Astler, M.D., Boynton Beach, Florida State Board of Medical Examiners; Robert E. Zellner, M.D., Orlando, Blue Shield of Florida; Jack A. MaCris, M.D., St. Petersburg, Medical District "B"; Richard C. Dever, M.D., Miami, Medical District "D"; James F. Cooney, M.D., West Palm Beach, Medical District "C"; Irving M. Essrig, M.D., Tampa, At Large; Burns A. Dobbins Jr., M.D., Fort Lauderdale, AMA Delegate; William M. C. Wilhoit, M.D., Pensacola, Medical District "A"; and Mr. W. Harold Parham, Jacksonville, Executive Vice President.

SHALL BE COMPOSED OF ONE REPRESENTATIVE FROM EACH SPECIALTY ORGANIZATION IN THE STATE OF FLORIDA OFFICIALLY RECOGNIZED BY THE FMA. RECOGNITION OF A FLORIDA SPECIALTY GROUP BY THE FMA SHALL AUTOMATICALLY ENTITLE THE RECOGNIZED GROUP TO REPRESENTATION ON THIS COUNCIL.

"EACH REPRESENTATIVE ON THE COUNCIL ON SPECIALTY MEDICINE SHALL BE ELECTED ANNUALLY BY THE SPECIALTY GROUP WHICH HE REPRESENTS, AND MAY BE RE-ELECTED TO AS MANY TERMS AS THE REPRESENTED ORGANIZATION SO DESIRES.

"THE PRESIDENT OF THE FMA SHALL APPOINT ANNUALLY A CHAIRMAN OF THE COUNCIL."

CHAPTER IX—COMMITTEES, Section 2, Composition, Selection and Tenure of Committees

Amend by adding a new Item #16, to read:

"16. Committee on Continuing Medical Education.—THIS COMMITTEE SHALL BE COMPOSED OF TWO REPRESENTATIVES FROM EACH MEDICAL DISTRICT, EACH FOR A FOUR-YEAR TERM ON A STAGGERED BASIS, AND ONE MEMBER AT LARGE APPOINTED EACH YEAR FOR A ONE YEAR TERM; ONE REPRESENTATIVE FROM EACH EXISTING FLORIDA MEDICAL SCHOOL, AND SUCH OTHER MEMBERS AND/OR CONSULTANTS AS THE PRESIDENT IN CONSULTATION WITH THE CHAIRMAN OF THE COUNCIL ON SCIENTIFIC ACTIVITIES MAY DEEM NECESSARY."

CHAPTER X—INCOME AND EXPENDITURES, Section 2, Dues.

Amend Item 7, Collection and Remittance of Dues, to read:

"Each component society shall collect all dues and assessments . . . and forward them to the Secretary of the Florida Medical Association on or before APRIL 1 annually."

CHAPTER XIV—AMENDMENTS, Section 1, By-Laws Amended

Amend by adding an additional paragraph to read:

"BY-LAWS AMENDMENTS ADOPTED BY THE HOUSE OF DELEGATES WILL BECOME EFFECTIVE UPON ADJOURNMENT OF THE HOUSE OF DELEGATES AT WHICH THE AMENDMENT IS ADOPTED."

(THE FOLLOWING AMENDMENTS ARE "CLEAN-UP" AMENDMENTS, WHICH IMPLEMENT CHANGES ADOPTED BY THE HOUSE OF DELEGATES PREVIOUSLY BUT WHICH WERE INADVERTENTLY NOT MADE IN THE BY-LAWS, AND ARE TO CORRECT TYPOGRAPHICAL ERRORS WHICH APPEAR.)

CHAPTER IV, HOUSE OF DELEGATES—Section 1, Designation and Composition: Amend to read: ". . . and the Speaker and the Vice SPEAKER of the House."

CHAPTER IX, COMMITTEES—Section 2, Composition, Selection and Tenure of Committees:

DELETE #1, Grievances.
DELETE #3, Medical Licensure
DELETE #12, Committee on Emergency Medical Service.

CHAPTER IX, COMMITTEES—Section 3, Duties and Functions:

DELETE Item #4, The Grievance Committee.
DELETE Item #7, The Committee on Medical Licensure

Amend Item #10 to read: "10. The Committee on CONTINUING MEDICAL EDUCATION . . ."

Ad Hoc Committee on the Structure of the FMA

The report of the Ad Hoc Committee on the Structure of the FMA was adopted as presented. (See Discussion, Report of the Board of Governors, page 55.)

Ad Hoc Committee On the Structure of the FMA

JOSEPH G. MATTHEWS, *Chairman*

The Ad Hoc Committee on the Structure of the FMA met at the Robert Meyer Motor Inn in Orlando on January 30, 1972, and made the following recommendations pertaining to the Council on Specialty Medicine:

RECOMMENDATIONS:

1. That the Council on Specialty Medicine be continued;

2. That the composition of the Council on Specialty Medicine be altered to include:
 (a) A single elected representative from each specialty organization recognized by the Florida Medical Association;
 (b) Each member's term shall be for one year, subject to re-election;
 (c) The chairman will continue to be appointed by the President of the Florida Medical Association.

3. That the purpose of the Council on Specialty Medicine be revised to include:
 (a) Representation of all specialty organizations within the Florida Medical Association;
 (b) Continuation of its advisory function to the Board of Governors of the FMA;
 (c) Privilege of the floor in the House of Delegates without a vote;
 (d) To consider such matters as may be referred to the council from the House of Delegates, Board of Governors, Executive Committee or President of the FMA;
 (e) To provide harmony and cohesiveness to the general body of medicine in Florida.

4. That Resolution 70-19, FMA Delegates, not be adopted.

5. That Resolution 71-2, specialty medicine representation, not be adopted.

The Speaker announced that the House would recess until Sunday morning at 9:00 a.m.

The Second Meeting of the House of Delegates recessed at 5:30 p.m.

Third House of Delegates

The third meeting of the House of Delegates convened at 9:00 a.m. on Sunday, May 7, 1972, in the Regency Room of the Diplomat Hotel, Hollywood, Florida, with Dr. Charles K. Donegan, Speaker of the House, presiding.

Dr. Wood, Chairman of the Credentials Committee, reported 172 delegates registered, constituting a quorum, and moved that the House be seated. The motion carried.

Delegates

ALACHUA—John W. Andrews, Henry J. Babers, George A. Dell, David M. Drylie, William C. Ruffin.
BAY—(Absent—James D. Nixon, W. Roland McArthur).
BREVARD—John T. Blackburn, T. John Kaminski, Paul Popovich, Joseph C. Von Thron.
BROWARD—Robert L. Andreae, Robert J. Brennan, Milton P. Caster, Richard S. Doyle, David C. Lane, J. Gordon McAllister, Ray E. Murphy, James B. Perry, Thomas F. Regan, Robert J. Steinborg, W. Dotson Wells (Absent—Russell B. Carson, Leonard A. Erdman, Joseph E. Gelety, Henry D. Perry Jr.)
CHARLOTTE—Robert Palmer.
CLAY—(Absent—Hinson L. Stephens).
COLLIER—Fred A. Butler, Nicholas H. Kalvin.
COLUMBIA—(Absent—Frank E. Adel).
DADE—Marvin Baker, Jerome Benson, Rufus K. Broadaway, Harvey E. Brown, Manuel L. Carbonell, Richard C. Clay, Jack Cleveland, Francis N. Cooke, Vincent P. Corso, DeWitt C. Daughtry, O. William Davenport, Joseph H. Davis, Richard C. Dever, Robert F. Dickey, Rudolph E. Drosd, Leon S. Eisenman, Miguel Figueroa Jr., Joseph Fitzgerald, Richard M. Fleming, M. Eugene Flipse Jr., Henry C. Hardin Jr., Marshall Hall, George Ioannides, Walter C. Jones III, John B. Liebler, Rose London, Ronald J. Mann, Charles A. Monnin Jr., Sheldon Munach, Richard Ravel, Robert Schiess, Daniel Seckinger, Everett Shocket, Chauncey M. Stone, Mario M. Stone, William Straight, Charles F. Tate, Maynard Taylor, Arthur W. Wood Jr., Scheffel H. Wright, Nelson Zivitz (Absent—William G. Aten, Edward W. Cullipher, M. Murray Schechter).
DESOTO-HARDEE-GLADES—Calvin W. Martin.
DUVAL—Warren M. Barrett, Clyde M. Collins, Emmet F. Ferguson Jr., Karl B. Hanson, M. Harlan Johnston, Leonard E. Masters, Thad M. Moseley, Harry W. Reinstine Jr., John A. Rush Jr., Guy T. Selander, Albert H. Wilkinson Jr. (Absent—Thomas S. Edwards).
ESCAMBIA—Charles J. Kahn, Philip B. Phillips, Theodore J. Marshall, William M.C. Wilhoit.
FRANKLIN-GULF—(Absent—Joseph P. Hendrix).
HIGHLANDS—Donald C. Hartwell.
HILLSBOROUGH—Ernest R. Bourkard, Frank C. Coleman, Richard G. Connar, Irving M. Essrig, John C. Fletcher, Richard S. Hodes, Victor H. Knight Jr., Thomas E. McKell, William W. Trice, Henry L. Wright Jr.
INDIAN RIVER—Charles C. Flood.
LAKE—J. Basil Hall, Thomas H. Nichols.
LEE-HENDRY—Larry P. Garrett, Francis L. Howington, Edward W. Salko.
LEON-WAKULLA-JEFFERSON—Edward G. Haskell, Nelson H. Kraeft, Robert N. Webster.
MADISON—None.
MANATEE—Irving E. Hall Jr., John D. Lehman, Roger A. Meyer.
MARION—Henry L. Harrell, C. Brooks Henderson.
MONROE—Joseph L.G. Lester Jr.
NASSAU—Marshall E. Groover Jr.
OKALOOSA—William W. Thompson.
ORANGE—Norman F. Coulter, Truett H. Frazier, Eugene N. Forrester, Paul C. Harding, Franklin B. McKechnie, Louis C. Murray, Franklin G. Norris, James F. Richards Jr., Edward W. Stoner, Thomas B. Thames, Joseph J. Williams.
OSCEOLA—Eugene R. Speirs.
PALM BEACH—Willard F. Ande, Carl E. Andrews, Vernon B. Astler, James R. Brandon, Jerry F. Cox, Dick L. Van Eldik, James R. Forlaw, Bernard Kimmel, Richard B. Moore (Absent—Curtis W. Cannon).
PANHANDLE—Herbert E. Brooks.
PASCO-HERNANDO-CITRUS—(Absent — W. Randall Jenkins).
PINELLAS—James C. Fleming, Allyn B. Giffin, David S. Hubbell, Jack A. MaCris, William G. Mason, W. Shands McKeithen, James H. Miller Jr., Donald G. Nikolaus, David T. Overbey, Walter H. Winchester, Rowland E. Wood.
POLK—Marvin G. Burdette, Thomas M. Caswall, J. Gerard Converse, John W. Glotfelty, Gordon R. Heath (Absent—Robert J. Pfaff).
PUTNAM—(Absent—Roy E. Campbell).
ST. JOHNS—William W. O'Connell.
ST. LUCIE-OKEECHOBEE-MARTIN—Howard C. McDermid, John F. Powers.
SANTA ROSA—(Absent—William N. Watson).
SARASOTA—John N. Carlson, Samuel E. Kaplan, F. E. Pfeiffenberger, Karl R. Rolls, Robert E. Windom.
SEMINOLE—John T. Johnson.
SUWANNEE-HAMILTON-LAFAYETTE — (Absent — Alex Kish).
TAYLOR—Frank Scarvey III.
VOLUSIA—William E. Carter, Harry G. Gillis, Richard W. Snodgrass, Charles A. Stump.
WALTON—(Absent—Howard F. Currie).
COUNCIL ON SPECIALTY MEDICINE—F. C. Andrews, Andre S. Capi, James W. Clower Jr., Samuel G. Hibbs, Sanford A. Mullen, Leo C. Nickell, John E. Startzman, James M. Stem, E. J. Sullivan, Miles W. Thomley (Absent—Jack H. Bowen, West Bitzer, Jacob Green, J. M. Hamilton, John R. Mahoney, Robert E. Raborn, Richard P. Thompson).

SPEAKER OF THE HOUSE—Charles K. Donegan.
VICE SPEAKER OF THE HOUSE—Franklin J. Evans.

The Speaker recognized distinguished guests present from allied professions: Mrs. Evelyn Lewis, R.D., Ft. Lauderdale, President-Elect, Florida Dietetic Association; Miss Helen P. Keefe, R.N., Orlando, President, Florida Nurses Association; Mr. Mark J. Sullivan, Tallahassee, President, Florida State Pharmaceutical Association; Mr. J. W. Ungaro, R.T., North Miami, President, Florida Society of Radiologic Technologists; Mrs. Vera M. Barnes, St. Augustine, President, Licensed Practical Nurses Association of Florida; and Mr. William H. Kelly, M.T., Lake Worth, President, Florida Society of Medical Technologists. The Speaker also recognized Dr. Theodore Bedwell, Director of the Bureau of Health Insurance, Department of HEW.

President Hurt called for an expression of appreciation to Dr. Richard Hodes for his outstanding job in the recent Legislature of representing the FMA and the people of Florida, and the House responded with applause.

Dr. Ray E. Murphy Jr., Chairman, Committee on Golf, announced the winners of the golf tournament:

Low Gross Division:
Champion—Dr. William M. C. Wilhoit, Pensacola
Runner-up—Dr. Joseph C. Von Thron, Cocoa Beach

Low Net Division:
Champion—Dr. William P. Smith, Coral Gables
Runner-up—Dr. Henry H. Bryant, Miami

Callaway:
Champion—Dr. Robert C. Piper, Coral Gables
Runner-up—Dr. M. Jeffrey White, Tampa

Co-Chairmen of the Committee on Tennis were Drs. Richard G. Connar and James H. Sternberg. Dr. Connar announced the winners of the tennis tournament:

Singles Open:
Dr. Alfred Lewis, Tallahassee
Singles 45 and over:
Dr. Richard G. Connar, Tampa
Doubles Open:
Drs. James H. Sternberg, Plantation, and Edward J. Saltzman, Hollywood
Doubles 45 and Over:
Drs. David Hubbell, St. Petersburg, and Richard G. Connar
Consolation Singles:
Dr. Sorrell L. Wolfson, Tampa
Consolation Doubles:
Drs. H. Phillip Hampton, Tampa, and Victor H. Knight Jr., Tampa

Dr. Connar expressed appreciation to Mr. Bill Gregg of the American Medical Tennis Association for coming to Miami to help with this tournament.

The Chairman of the Fishing Committee, Dr. Hobart T. Feldman, was unable to be present for a report on this activity.

The winner of the fishing tournament was Mrs. H. L. Wright (Ann) of Tampa who caught an 84″ sail fish.

Continuation of

Report of Reference Committee No. III
Finance and Administration

President's Address

The Reference Committee acknowledged its assignment to consider the report of President Floyd K. Hurt, M.D., as presented in his address to the First House of Delegates on Wednesday, and recommended that his address be adopted as presented, with the gratitude of the House for the words of wisdom and guidance which it supplied.

It was adopted. (The President's address begins on page 21).

Remarks of the Speaker of the House

The Reference Committee heard the Remarks of the Speaker of the House as presented to the House at its First Meeting on Wednesday, and expressed its appreciation for the enlightenment, information and instructions contained therein.

The Speaker's remarks were adopted as presented. (The Remarks of the Speaker appear on page 29.)

Report of the Board of Governors Representative from the State Board of Medical Examiners

Upon recommendation of the Reference Committee the report of the Board of Governors representative from the State Board of Medical Examiners was filed.

Committee on AMA House of Delegates

Upon recommendation of the Reference Committee the report of the Committee on AMA House of Delegates was filed.

Florida Medical Foundation

Upon recommendation of the Reference Committee the report of the Florida Medical Foundation was filed.

Judicial Council

Upon recommendation of the Reference Committee the report of the Judicial Council was adopted as printed.

Judicial Council

VINCENT P. CORSO, *Chairman*

It seems appropriate to preface the Judicial Council's 1972 report to the House of Delegates with some remarks about the Council's experience through the first year following rather extensive revisions to the FMA By-Laws.

Until the Annual Meeting of 1971, the Council consisted of a Chairman appointed by the President of FMA and the Chairman of Committees on Membership and Discipline, Grievance, Medical Licensure and Archives, and a representative of the Board of Past Presidents.

The House of Delegates, in 1971, abolished the Grievance and Medical Licensure committees and transferred the Committee on Archives to another Council, leaving only the Membership and Discipline Committee within the framework of the Judicial Council. The House enacted amendments providing for the election of Council members to five-year terms on recommendation by the Board of Governors and with the concurrence of each candidate's county medical society. Current By-Laws also provide that one Council member shall be elected from each of the four Medical Districts and one shall be elected from the State at large. Individual service is restricted to two consecutive five-year terms.

In abolishing the Grievance and Medical Licensure Committees, the House prescribed that the Council would elect one of its members to serve as liaison to the Florida State Board of Medical Examiners and one to supervise the processing and adjudication of grievances and complaints from the general public. Accordingly, John J.



Among ladies attending the Awards Luncheon of the Woman's Auxiliary to the Florida Medical Association were (seated, left to right): Mrs. Russell B. Carson, Fort Lauderdale, a Past President; Mrs. Chauncey M. Stone Jr., Miami; Mrs. Ray E. Murphy Jr., Pompano Beach, First Vice President; Mrs. William L. Read, Winter Haven, AMA-ERF Chairman; Mrs. Quillian Jones, Fort Myers, a Past President; Mrs. R. B. Moore Jr., West Palm Beach, Recording Secretary; and Mrs. W. H. Mathews, Jacksonville, President Elect. Standing: Mrs. Floyd K. Hurt, Jacksonville, Mrs. William J. Dean, St. Petersburg, and Mrs. Christopher McConnell, President Elect of the Woman's Auxiliary to the Student American Medical Association.

Cheleden, M.D., was designated as liaison to the Board of Medical Examiners, of which he also is a member, and James A. Winslow, M.D., was assigned responsibility for grievances.

Your Council believes that the 1971 amendments governing its organization and activities, as well as practices and procedures it has adopted on its own volition have enhanced its effectiveness markedly. It is now better equipped to keep pace with its ever-expanding role of ombudsman in a rapidly growing professional organization.

As the Florida Medical Association has grown, so have the demands placed upon this Council. So that each and every matter can get the attention it deserves, your Council now is meeting quarterly, for two days at each meeting. Meetings are held in February, June, September, and December, with each meeting date and place decided upon a full year in advance. Other meetings may be arranged as needed.

Rules and Procedures of the Judicial Council: The Council has revised its Rules and Procedures consistent with organizational changes dictated by the 1971 By-Law amendments and in the light of its increasing responsibilities, requests endorsement thereof by the House of Delegates (See Recommendation No. 1).

Osteopathy: Virtually all matters relating to osteopathy eventually come before this Council one way or another. Since the House of Delegates, in 1970, adopted Resolution 70-4 (Osteopathy), your Council has endorsed policy statements on osteopathy submitted by eleven component medical societies. These are Alachua, Broward, Dade, Duval, Hillsborough, Highlands, Marion, Clay, Orange, Volusia and Pinellas.

Your Council feels that all component societies should be implored to develop policies on osteopathy and submit them for review by the Judicial Council in accordance with Resolution 70-4 (See Recommendation No. 2). If this were done, one would he able to ascertain the official status of M.D.-D.O. relations in any county of the State.

There has been some debate in the past as to whether FMA should organize a liaison committee on osteopathy. At its October meeting, the Board of Governors disapproved the Council's petition for authority to contact leaders of the osteopathy profession in Florida to determine whether they feel such a committee could be useful at this time. Your Council does not necessarily feel that such a committee is needed at this time inasmuch as osteopathy continues to be a question demanding local approaches. However, there no doubt will come a time—perhaps not too far in the future—when official dialog with osteopathy at the state level becomes desirable, and the Florida Medical Association must be prepared for it.

Your Council makes no further specific recommendations at this time regarding state-level liaison with the osteopathy profession. But it is felt that this Council should be given some significant role at such time as such relationships are established. For example, the liaison committee might report to the FMA through the Judicial Council.

Medical Faculty Certificate: A 1971 amendment to the Medical Practice Act made provision for a Medical Faculty Certificate, permitting a physician member of the faculty of any Florida medical school to practice medicine in conjunction with his teaching duties for a period not to exceed one year. The Judicial Council was asked to interpret the By-Laws to determine whether the holders of such certificates would be eligible for active dues-paying membership in the Florida Medical Association. The Council determined that these physicians would not be eligible for such membership but might qualify for associate membership.

The Council also was asked to make a recommendation as to whether physicians in practice under authority of a medical faculty certificate should be issued Blue Shield participating physician numbers.

The Council is of the opinion that the Medical Faculty Certificate, in effect, entitles the holder to practice medicine without restriction within an institutional environment for a specified period of time. Therefore, it is felt such physicians should be eligible for Blue Shield participating physician numbers.

County Medical Societies: The House of Delegates, in 1971, authorized the chartering of the Osceola County Medical Society, subject to the proposed component's submission of acceptable constitution and by-laws and final approval by the Judicial Council. These documents were submitted, and a charter dated September 25, 1971, was presented to the Osceola County Medical Society on November 9, 1971.

The Council was asked to look into the membership status of the Franklin-Gulf County Medical Society. FMA By-Laws require each component to have at least five active members, and it was believed that the membership in this component society had dropped to four. Upon investigation, it was found that a fifth member of the society had been reported erroneously as an associate, when he should have been reported as an active member. Inasmuch as the minimum membership is maintained, the Council recommended to the Board of Governors that Franklin-Gulf's charter remain active.

In yet another county medical society membership matter, the Council considered a petition signed by all four members of the Lee-Hendry County Medical Society who reside and practice in Hendry County for transfer to the Palm Beach County Medical Society. Both county medical societies were invited to comment on the petition, and the Council's suggested action in this matter appears as Recommendation No. 3.

Grievances and Complaints: Between May, 1971, and February 1, 1972, the Judicial Council received 19 complaints filed by laymen against members of FMA. Under the rules and procedures of this Council, these were referred to the appropriate county medical society grievance committees for inquiry and report. While most of these cases were handled adequately within a reasonable length of time, some local committees had to be prodded into action.

During the same period, 13 cases were closed.

Most complaints filed by the public are of a relatively minor nature and probably could have been avoided through better communication between doctor and patient. A few complaints on their face are patently unjustified, but they are investigated with equal fervor.

Of particular concern to your Council is what seems to be the growing number of quarrels in which physicians and their hospital boards or physicians and their fellow physicians are adversaries. Such unfortunate situations, if permitted to fester, can lead only to degradation of the profession and serious deterioration of medical care in the communities involved.

Only limited success has been achieved in efforts to resolve these controversies. Your Council prefers, of course, that these cases be resolved by the county medical societies, with the assistance of local members of the Committee on Membership and Discipline. However, there are cases in which the county societies are reluctant to act for various reasons.

In its experience with both lay and profession-generated complaints, your Council perceives some lack of understanding on the part of some members of the profession of the proper procedures to resolve these disputes. So that all concerned may be made aware of the judicial procedures of the Florida Medical Association, your Council is suggesting that FMA sponsor a Statewide Conference on Medical Ethics and Discipline (See Recommendation No. 4).

Physician Billing Survey: In the summer of 1971, your Council launched—through its Committee on Membership and Discipline—a statewide survey of billing procedures of hospital-based physicians. (See Report of Committee on Membership and Discipline). At its October meeting, the Board of Governors asked the Council to involve specialty groups in this project. In accordance with the Board action, the Council has arranged a meeting with specialty society representatives during the 1972 Annual Meeting of the Florida Medical Association.

Contract Review: The Council has continued to review contracts for medical services between hospitals and physicians to determine whether they measure up to the ethical standards of the Florida Medical Association. The most common cause for rejection is provision of straight salary for patient care or other medical services. Under a newly-instituted review procedure each contract is seen by three members of the Council and the Membership and Discipline Committee. A copy of each contract is sent to one of the four Membership and Discipline Committee members in the area involved, to the Chairman of the Committee on Membership and Discipline, and to one other member of the Judicial Council. If these three individuals are in agreement in a determination of ethicality, then that determination becomes the official decision of the Council. If, on the other hand, there is a significant difference of opinion among the three reviewers, the contract is held up for review by the Judicial Council at its next quarterly meeting.

Yellow Page Directory Listings: From time to time questions relating to the listing of physicians in telephone directory yellow pages are presented to this Council. It should be noted that this is a matter which customarily has been left to the discretion of county medical societies. Recognizing that the county medical society is the final arbiter, the Judicial Council has in the past rendered advice upon request, and will continue to do so.

At times the Council is asked about listings of other professions such as podiatrists. These are matters of no concern to either the Council or the county medical societies so long as there is no evidence that these personnel are implying falsely that they are licensed as doctors of medicine.

Day and Night Emergency Service: In the past year we have seen the rapid development of several lay-operated organizations which provide emergency house call service. The modus operandi varies somewhat, and the Council has no objection provided they are operated within guidelines spelled out in Opinion 71-10 (See below).

Opinions of the Council: In response to specific questions, the Council has rendered the following formal opinions within the past year:

Opinion No. 71-1: The Judicial Council is of the opinion that it is not unethical for a physician to adopt the child of one of his patients, provided the adoption is consummated within the framework of all applicable laws, rules and regulations. (6/12/71)

Opinion No. 71-2: The Judicial Council is of the opinion that a physician may use ethically either "Dr." before his name or "M.D." after his name in political campaign advertising. (6/12/71)

Opinion No. 71-3: The Council sees no objection to a presurgical agreement between physician and patient as to terms of payment provided such agreement does not in any way penalize the patient with interest or carrying charge for an overdue account. (6/12/71)

Opinion No. 71-4: The Council believes that inasmuch as Health Maintenance Organizations are not clearly defined at this point in time, it would not be practical to develop ethical standards in any detail. However, any physician contemplating providing medical service in an HMO setting should always be aware of Section 6 of the Principles of Medical Ethics and particularly those ethics covering conditions of medical practice, contract practice, purveyal of medical service to direct profit of lay group, practice of medicine by lay corporations, and lay corporations. (9/25/71)



Next year, when the Delegates call out "Mr. Speaker!" they will be addressing Franklin J. Evans, M.D., Coral Gables (above). Dr. Evans, who also has a law degree, was promoted by the House of Delegates from Vice Speaker to Speaker.

Opinion No. 71-5: In the opinion of the Council, a surgeon may use his office associate as his assistant in surgery, but the associate is entitled to a fee only for procedures wherein the hospital rules and regulations require an assistant in the operating room. In such cases, a separate bill must be presented to the patient in the name of the associate/assistant. (9/25/71)

Opinion No. 71-6: The Council does not take exception to a tasteful acknowledgement of a physician's financial or other type of contribution to his civic club. There is no objection to the simple listing of the physician's name, either with or without his degree or title (M.D. or Dr.) in a civic club bulletin under such headings as "acknowledgements" or "patrons." However, a physician should never permit his specialty to be listed or his name to be listed on a page headed by the caption "classified advertising," "classified," "advertising" or any similar heading that would seem to imply advertising of his services. (9/25/71)

Opinion No. 71-7: The Council is of the opinion—in the absence of local policy to the contrary—it is not improper for a physician to purchase newspaper space to announce opening, removal or closing of his office or the association of another physician in his practice, subject to certain restrictions. The newspaper in which space is purchased should circulate primarily in the area in which the physician's office is located; the purchased space should be no larger than two

columns in width by two inches in depth; type should be of conservative and light face; and the announcement should be published for no more than one week. Only black ink is permitted, and no attention getting devices are allowed. (9/25/71)

Opinion No. 71-8: In view of Resolution 70-4, the Council believes it would be presumptuous to rule on the question of whether an M.D. should be allowed to affiliate with the medical staff of an osteopathic hospital. However, the Council believes that it is pertinent to remind those physicians who affiliate with these institutions that they must take care to retain their identity as M.D.'s and that they are at all times governed by the Principles of Medical Ethics of the AMA and FMA. (9/25/71)

Opinion No. 71-9: In view of Resolution 70-4, the Council believes it would be improper for it to rule on the question of whether an M.D. pathologist, radiologist or other specialist may provide such services as interpretation of x-rays, tissue examinations, etc., for an osteopathic hospital. However, any M.D. providing such services, either in his own office or on the premises of an osteopathic hospital, must render a separate bill for his services, take whatever other steps are necessary to protect his identity as an M.D., and abide at all times by the Principles of Medical Ethics of the AMA and the FMA. (9/25/71)

Opinion No. 71-10: In the opinion of the Judicial Council, there is a place in the health care delivery system for organized services which provide physicians with coverage of their medical practices at night, on weekends and during vacation periods. However, the Council's approval of these services assumes that all physicians participating in any way will at all times abide by the Principles of Medical Ethics. It is ethical for a physician to pay a fee to a layman if it is the layman's only function to assure that there is an adequate number of physicians on call or available to provide adequate practice coverage. The layman who supervises such a service must not pay a salary to any physician providing after-hours coverage, nor shall such a layman collect or share in a fee paid by a patient for medical service. Physicians agreeing to provide coverage through this type of service must be licensed by the Florida State Board of Medical Examiners. The fee paid for after-hours medical service is a matter of concern only to the physician who rendered the service and the patient.

Your Council submits the following recommendations to the House of Delegates:

RECOMMENDATIONS

1. That the House of Delegates concur in revised rules and procedures of the Judicial Council as approved by the Council on June 12, 1971:

 A. The Judicial Council shall have original jurisdiction, both as to fact and procedure, in all questions and controversies which pertain to interpretation of the Charter and By-laws, Medical Ethics, dissension and disputes among members, grievances, membership and discipline. Opinions of the Judicial Council shall be final.

 In any investigation regarding a member of the Association by the Judicial Council or any of its committees, the physician or physicians being investigated shall have the opportunity to appear before the council or committee and present statements of fact in their own behalf.

 B. Requests for interpretation of the Charter and By-laws shall be referred to the Judicial Council for an opinion. Requests shall be in writing. The Judicial Council on its own motion may render an opinion concerning the interpretation or application of the Charter and By-laws.

 C. The Judicial Council shall hear and weigh complaints from the public (patients) relative to the profession and to medical practices. The member of the Judicial Council designated to handle grievances shall be empowered to investigate these complaints or refer them to the grievance committee of the appropriate component society for investigation and an opinion. If the component county medical society does not act within one-hundred and eighty days (180) the council shall assume original jurisdiction, and make whatever investigation deemed necessary.

 If a complaint referred to a component society is not adjudicated expeditiously or satisfactorily, the designated council member shall attempt to determine what has caused the delay or dissatisfaction and shall reopen the case on the Association level if such a procedure is deemed necessary and advisable. In the event a hearing for appeal at the state level is required, the council member may request that the appropriate district representatives of the Committee on Membership and Discipline act for the council in the disposition of the complaint. If the findings indicate that censorship or other dis-

ciplinary action against the member or members against whom the complaint was filed is in order, the Judicial Council shall request that this action be taken by the member's component society. Failure of the society to comply with the request shall be cause for the Judicial Council itself to act.

Each member against whom charges are preferred shall have such charges presented to him in writing and shall have the opportunity, if desired, to appear before the Judicial Council.

D. Dissension and disputes among members of the Association, questions regarding membership, disciplining of members, factualness of medical testimony, medical ethics, professional competency, complaints from other councils of the Association, other organizations or agencies, shall be investigated by the Committee on Membership and Discipline, and its recommendations reviewed by the Judicial Council.

E. Complete findings and recommendations as to disciplinary action shall be made through the Board of Governors and if the disciplinary action recommended by the Judicial Council involves (1) medical ethics, the Board shall recommend appropriate action by the component county medical society; or (2) matters of law, whether civil or criminal, it shall be referred to the Judicial Council for reporting to the State Board of Medical Examiners.

F. The Judicial Council shall from time to time review the state laws dealing with medical licensure for recommended changes or corrections. It shall receive, review, and make recommendations on all proposals dealing with medical licensure in the state.

G. In instances where a component county medical society has discovered evidence of illegal or unethical conduct, or professional incapacity or incompetency, it shall be referred to the Judicial Council of the Association, who will in turn refer such matters to the Florida State Board of Medical Examiners.

2. That all county societies which have not done so be encouraged to inform the Council of their official position on osteopathy in accordance with Resolution 70-4.

3. That Hendry County, wherein no county medical society is at present organized, be transferred from the Lee-Hendry County Medical Society to the Palm Beach County Medical Society under the provisions of paragraph 8, "Unorganized counties assigned to societies", section 3, "membership", chapter XI, "component societies", FMA By-Laws; and the Lee-Hendry County Medical Society be rechartered to reflect the removal of Hendry County from its area of jurisdiction.

4. That FMA sponsor a statewide conference on medical ethics and discipline as a means of acquainting members of the Committee on Membership and Discipline, County Medical Society officers and grievance committee members, and others with the disciplinary procedures of the Florida Medical Association, and to instruct them as to their role in this important function of organized medicine.

Committee on Membership and Discipline.—Your Committee on Membership and Discipline functions as a trouble-shooting field division of the Judicial Council. At the present time, this Committee consists of 48 members, four from each of Florida's 12 congressional districts. Because of Florida's population growth through the 1960's, the State has earned three additional congressional seats, and this means the Membership and Discipline Committee will be enlarged, this year or next, to 60 members.

The Committee on Membership and Discipline is much too large to function as a single unit. It is considered that the Committee actually is a group of four-member district subcommittees, and it is on this basis that the Committee best performs its functions.

Members of the Committee serve both the Judicial Council and the Florida State Board of Medical Examiners. In the latter role, they function as official deputies. Committee members assist in the policing of the Medical Practice Act for the Board of Medical Examiners.

The Committee's responsibilities to the Judicial Council include, among other things, review of hospital-physician contracts, and serving as peacemakers and trouble-shooters in localized disputes between physicians and between physicians and their hospitals.

The principal project of the Committee in the past year has been the statewide survey of billing arrangements of hospital-based physicians. The Committee was provided with Blue Shield information relating to billing practices in Florida hospitals (separate vs. combined billing). Such information was listed for typical hospital services, including pathology and radiology, EKG and EEG interpretation, etc.

First objective of the project was to verify the information supplied. The second objective was to encourage all hospital-based specialists known to participate in combined billing to convert to separate billing.

Remarkable progress has been noted in some of the 12 districts toward accomplishing both objectives. In certain other districts, there has been very little progress. Because of the variety of ways in which the district subcommittees report to the Judicial Council, a final definitive report must await completion of the project.

The Board of Governors asked the Judicial Council to invite specialty groups to participate in this investigation. Accordingly, the Council will meet during the 1972 FMA Annual Meeting with representatives of the specialties of pathology, radiology, neurology and internal medicine. It is felt that representatives of these specialties might be particularly helpful in encouraging their members to embrace separate billing.

Both the Committee on Membership and Discipline and the Judicial Council are aware that the nature of the

practice of pathology makes it difficult for its practitioners to become parties to ethical contracts by the same standards as other specialists. Study should be made on this problem (See Recommendation No. 1).

RECOMMENDATION

1. **That the Florida Medical Association explore with the Florida Society of Pathologists, and possibly with the Florida Hospital Association, ways of developing hospital-pathology contracts which meet the ethical criteria of FMA.**

Report of the Liaison Representative to the Florida State Board of Medical Examiners (John J. Cheleden). —In 1971, 2,728 applicants for license to practice medicine in Florida were examined and of these, 1,961 passed. There were 767 failures, a failure rate of 28.1%. For the first time in the history of medical licensure in this State, 134 additional licenses were granted by endorsement—a total of 2,095 new licenses issued for the year 1971.

In January, 1972, 976 applicants were examined. Of this number, 567 passed and 409 failed—a total failure rate of 41.9%. There were 496 U.S. graduates in this group; 28% failed. Foreign medical school graduates numbered 480 and 56% failed. An additional 54 licenses were issued by endorsement.

For comparison, in 1970, 2,345 candidates were examined and 1,759 were granted licenses—a failure rate of 24.9%. In this group, 684 were graduates of foreign medical schools; 412 passed and 269 failed—a failure rate of 39.5%.

Because of several amendments to the Medical Practice Act, effective July 1, 1969, and additional legislation passed subsequent to this, all activities of the Board of Medical Examiners have increased. The number of meetings yearly has increased from four to six meetings in 1971, and eight meetings will probably be necessary in 1972. Investigations increased from 29 in 1970, to 127 in 1971. The number of hearings increased from 38 in 1970, to 61 in 1971. During 1971, there were seven denials of application for licensure, one license revoked, 10 licenses suspended, 15 M.D.'s put on probation up to two years, three M.D.'s were reprimanded, six probations terminated and six licenses reinstated.

Endorsement.— Beginning July 1, 1971, the Medical Practice Act provides for the issuance of a license by endorsement. The provisions of this amendment are as follows: (a) if the candidate passes the examination given by the National Board of Medical Examiners, or (b) passes the Federation of State Medical Board Examination (FLEX), he may be issued a license by endorsement. The Florida State Board of Medical Examiners has the authority to further examine such candidates by oral or written examination if it is deemed necessary. A physician granted a license by endorsement is compelled to establish a practice in the State of Florida within a period of three years. Otherwise, the license is automatically revoked. Application for license in Florida must be made within eight years after taking either the National Board examination or the FLEX examination. As of February 1972, 39 of the 50 states are using FLEX examinations and through this mechanism we now have reciprocity with thirty-nine states.

Academic Licenses.—The Board can issue a temporary license to a physician employed as a teacher in one of the recognized medical schools allowing him to practice in connection with teaching duties in the medical school and its hospital. The license will become void upon termination of employment or after a period of one year, whichever occurs first. The law specifically states that an academic license authorizes the holder to practice only in conjunction with his teaching duties at a medical school or its main teaching hospital. The holder of such a license is not permitted part-time private practice.

As of December 31, 1971, the annual registration of M.D.'s licensed to practice in Florida was 15,571 with 9,269 having in-state addresses. The physician population ratio in the State of Florida is now approximately 1:850. Maldistribution of physicians remains both a state and a national problem.

During the past year, the Board received for information the proposed Ph.D.-to-M.D. program of the University of Miami School of Medicine. A description of this program, initiated July 1971, was presented in detail by Dean Emanuel Papper. The Board instructed Dr. Palmer to write the AMA Council on Medical Education and the Association of American Medical Colleges regarding their attitude and position on the Ph.D.-M.D. program.

Dean Donn L. Smith, of the University of South Florida School of Medicine, discussed their three year curriculum with students attending school 11 months of the year.

The Board tentatively approved the list of schools with physician's assistant programs with courses of 24 months —as published in the October 25, 1971 issue of the *American Medical News*. This approval was subject to final approval by the AMA. The physician's assistant training program to be conducted by the Santa Fe Community College and University of Florida (a two-year course) was approved tentatively by the Board subject to (1) annual review by the Board and (2) the acquisition of approval of the program by the AMA accrediting body for programs for physician's assistants. Dr. Richard A. Henry, Assistant Professor, Department of Community Health and Family Medicine, University of Florida, was instructed to (1) apply for certification to have a physician's assistant and (2) the two physician's assistants he has working for him in Trenton, Florida, apply for certification as physician's assistant and (3) to adhere to the physician's assistant amendment to the Medical Practice Act.

The Board authorized Courtlandt D. Berry, M.D., to visit the medical school of the Autonomous University of Guadalajara, Mexico, for the purpose of inspecting and evaluating the type and caliber of medical education at the University and also to gain insight about, and be able to evaluate in a general way, the type of medical education in Mexico. Dr. Berry, who speaks fluent Spanish, then reported to the Board following his on-the-spot visit and the information thus gathered will prove most valuable to the Board in evaluating graduates of the school and matters relating to the suit brought against the AMA by American students who are enrolled there.

Health Maintenance Organizations (HMO's).—The Board ruled that a Florida license is required of all physicians employed in an HMO.

Ten M.D.'s on the Board are all in active practice and each member spends a minimum of 21 days out of his office each year on Board business. The Executive Director, George S. Palmer, M.D., is on a full-time basis. His office is located in Tallahassee. The State Board of Medical Examiners functions under the Department of Professional & Occupational Regulation, Division of Professions.

Members of the Board are: Vernon B. Astler, M.D., President, Boynton Beach; Courtlandt D. Berry, M.D., Naples; Gerald D. N. Bryant Jr., M.D., Tallahassee; John J. Cheleden, M.D., Daytona Beach; Leo Grossman, M.D., Miami Beach; Leonard F. Hattaway, M.D., Pensacola; Charles B. McIntosh, M.D., Jacksonville; Carl C. Mendoza, M.D., Jacksonville; John E. Orebaugh, M.D., St. Petersburg; and Madison R. Pope, M.D., Plant City.

In the fiscal year 1971-1972, the operating budget is $290,750. An added responsibility of the Board effective July 1, 1971, is certification of the new category of allied health personnel, physician's assistants, and certification of licensed physicians to have physician's assistants.

The Board desires the cooperation of all M.D.'s in organized medicine, especially in the area of reporting M.D.'s who might come under the provision of the Sick Doctor Amendment. In addition, it requests that all county medical societies report to the State Board of Medical Examiners any denial of membership or any disciplinary action taken by any society against a physician.

In the past year there has been close liaison with members of the FMA Committee on Membership and Discipline. This committee now numbers 48 and will shortly be increased to 60 and all members are deputized to aid the Board in carrying out all functions as delineated in the Medical Practice Act. The Membership and Discipline Committee functions under the Judicial Council of the Florida Medical Association.

Council on Special Activities

Upon recommendation of the Reference Committee the report of the Council on Special Activities was adopted as published.

Council on Special Activities

JACK Q. CLEVELAND, *Chairman*

The Council underwent a change in structure this year with the By-Laws amendments of May, 1971. The function of the Advisory to the Woman's Auxiliary was assumed by the Executive Committee, and the Council gained the Committee on Archives as a new responsibility. This committee along with the Board of Past Presidents makes up the Council.

Committee on Archives—The August issue of the FMA Journal will once again be the "historical" issue, carrying a series of biographical sketches of early physicians who contributed to the development of medicine in Florida.

Plans are still underway for the erection of a plaque at the site of the founding of the Florida Medical Association in Jacksonville in 1874.

The Committee plans to recognize members who joined during 1944 and 1945 during the annual meeting this year.

The History of Medicine Museum in the Spanish Military Hospital in St. Augustine remains one of the major projects of the Committee. The Woman's Auxiliary to the FMA has adopted this also as one of its projects, and in 1971 donated the proceeds from the Art Exhibit at the annual meeting to this museum in the amount of $525. The Auxiliary plans once again in 1972 to give the proceeds of the Art Exhibit for the development of the second floor of this museum.

During the past year, the Association has lost a number of its valued members whose names are included in the Delegates' packet and in whose honor the Memorial Service will be held.

Board of Past Presidents—The Board of Past Presidents met for its annual breakfast meeting during the 1971 annual meeting with 14 past presidents in attendance. Members of the Board enjoy this get-together, and are looking forward to the meeting this year. The past presidents, collectively and individually, stand ready and willing to be of assistance to the Association whenever necessary.

Supplemental Report Committee on Archives

The Reference Committee recommended that the following names be included in the Supplemental Report of the Committee on Archives:

Bransford, Lee E. Sr.—Duval
Brown, Harry W.—Pinellas
Cunningham, Charles B.—Pinellas
Payne, Walter C. Sr.—Escambia

The Supplemental Report of the Committee on Archives was adopted as amended.

Supplemental Report Committee on Archives

MARGARET PALMER, *Chairman*

The Association has lost a number of its fine members during the past year and a list of these names is given below.

June 1970
Smoak, Edward—Hillsborough
September 1970
Meehan, Matthias P.—Dade
October 1970
Raap, Gerard—Dade
December 1970
Farrington, Robert F.—Dade
January 1971
Ebert, William B.—Broward
Nix, Oscar G.—Escambia
March 1971
Hasty, Frederick E.—Dade
April 1971
Martin, Richard A.—Broward
Sample, Adrian M.—St. Lucie-Okeechobee-Martin
May 1971
Broward, John A.—Dade
Harris, Robert M.—Dade
Howell, R. Spencer—Dade
Weiner, James M.—Dade
June 1971
Chittenden, George E.—Orange
Feaster, Orion O.—Pinellas
Gable, N. Worth—Pinellas
Lockwood, Raymond M.—Pinellas
Snedeker, Bernard C.—Broward
Van Landingham, William E.—Palm Beach
July 1971
Cantor, Jack L.—Dade
Montague, Fairfax E.—Putnam
Whitney, Homer H.—Hillsborough
Willis, W. Russell—Orange
August 1971
Coxe, Lemuel F. Jr.—Bay
Gunsolus, John M.—St. Lucie-Okeechobee-Martin
Hicks, Lawrence—Escambia
Klein, Warren E.—Broward
Wolf, Richard S.—Dade
September 1971
Adickes, Edward J.—Brevard
Buchanan, Arthur P.—Lake
Campbell, Francis J. —Dade
Habegger, Myron L.—Brevard
October 1971
Cope, Paul T.—Pinellas
November 1971
Gilbert, Michel G.—Dade
December 1971
Bolton, Patricia O.—Broward
Garcia, Jose C.—Broward
Hall, Young L. Jr.—Dade
Long, James A. Jr.—Putnam
Mason, Charlotte E.—Broward
January 1972
Cawthon, William D.—Okaloosa
Graham, Henry H.—Alachua
Gwynn, Humphrey W.—Orange
McGehee, Nat T. Jr.—Broward
Renwick, John A.—Dade
Spaulding, Earl M.—Escambia
Tolle, Robert L.—Orange
February 1972
Adair, Fred L.—Orange
Davis, Kenneth M.—Palm Beach
Levine, Sanford—Dade
McCorkle, Albert W.—Dade

Moeller, Maximilian W.—Pinellas
Neuwirth, Abraham A.—Hillsborough
March 1972
Diehl, Earl H.—Hillsborough
Judd, Robert C.—Palm Beach
Langston, Henry I.—Okaloosa
Newquist, Melvin N.—Pinellas
Watson, John E.—Duval
West, J. Richard—Volusia
Wrenn, Simeon M.—Orange
April 1972
Brown, Harry W.—Pinellas
Cunningham, Charles B.—Pinellas
Eyster, William H. Jr.—Volusia
May 1972
Bransford, Lee E. Sr.—Duval
Payne, Walter C. Sr.—Escambia
Date Unknown
Marshall, Otis—Duval

Council on Scientific Activities Recommendation No. 7

The Reference Committee recommended that Recommendation No. 7 of the Council on Scientific Activities be filed as the By-Laws amendment to accomplish this had already been adopted.

It was filed.

(See Report of Council on Scientific Activities, page 35.)

Council on Medical Services Recommendation No. 15

The Reference Committee recommended that Recommendation No. 15 of the Council on Medical Services be filed as By-Laws amendment to accomplish this had already been adopted.

It was filed.

(See Report of Council on Medical Services, page 45.)

Resolution 72-15 Osteopathy Liaison Board of Governors

Resolution 72-15 was adopted as presented. (See Discussion, Board of Governors Report, page 60.)

Resolution 72-15

Osteopathy Liaison

RESOLVED, That a Liaison Committee be established between the Florida Medical Association and the Florida Osteopathic Medical Association.

Resolution 72-12 Physicians' Guild Palm Beach County Medical Society

The Reference Committee proposed a substitute for Resolution 72-12, Physicians' Guild.

A motion was made from the floor that the Reference Committee's substitute for Resolution 72-12 be amended by deleting Items 2 and 3.

The amendment from the floor was defeated.

The substitute for Resolution 72-12, Physicians' Guild, to be called Substitute Resolution 72-12, Physicians' Guild, was adopted.

Substitute Resolution 72-12

Physicians' Guild

RESOLVED, That the Florida Medical Association 1) declare itself not to be a union of physicians, 2) recognize the need for the Florida Physicians Association, Inc. and 3) recommend that its members join this organization.

Resolution 72-13 FMA Headquarters Broward County Medical Association

The Reference Committee did not consider Resolution 72-13 as no sponsor was present at the Reference Committee Hearing.

Resolution 72-16 Relocation of FMA Headquarters Collier County Medical Society

The Reference Committee reported that it had considered Resolution 72-16, Relocation of FMA Headquarters, and took note of the financial impracticabilities of moving the Association Headquarters at the present time, and although there may be reasons in the future for reconsideration, it recommended that Resolution 72-16 not be adopted.

The Speaker recognized Dr. Jere W. Annis, Past President. Dr. Annis gave the following report regarding a point of order and relating to Resolution 72-16:

"The Board of Past Presidents has requested that I make the following report, representing its unanimous opinion.



Mrs. Arnold J. Spanjers, Winter Haven, officially concludes Mrs. Wesley S. Nock's year as President of the Woman's Auxiliary to the Florida Medical Association by presenting her with her Past President's Pin.

"This House of Delegates has always been and continues to be the ultimate and final authority in all matters of policy and principle in the FMA. It has, however, wisely delegated certain duties and obligations to its Board of Governors for more efficient, effective and currently responsive operation—among these are such housekeeping chores as the employment of staff, location and operation of a Headquarters office, and the establishment of the time and place of annual meeting—the House may, of course, act in an advisory capacity to the Board by expressing its desires in these areas and requesting deeper study of them, or it may, by amending the By-Laws, withdraw from the Board these delegated duties.

"Short of this, we, the Past Presidents, feel it important to preserve the orderly parliamentary conduct of our organization's affairs by requesting that future resolutions directed toward a change in those functions delegated to the Board be made in the form of suggestions to the Board for further consideration. We respectfully submit this observation in the interest of smoother parliamentary procedure.

"We concur in the recommendation of the Reference Committee."

Resolution 72-16, Relocation of FMA Headquarters, was not adopted.

Resolution 72-25
Legislative Session of the House of Delegates
Hillsborough County Medical Association

The Reference Committee recommended that Resolution 72-25, Legislative Session of the House of Delegates, be approved in principle but felt that the practical aspects of it would require further consideration. The Committee recommended that Resolution 72-25 be referred to the Board of Governors for further study.

Resolution 72-25 was referred to the Board of Governors.

The Reference Committee also recommended that the Council on Legislation and Public Agencies meet with county medical society officers present at the FMA Leadership Conference in 1973 for the purpose of outlining problems and soliciting solutions from the component county medical societies concerning the upcoming Legislative Session.

The recommendation was adopted.

Resolution 72-25

[Not adopted—Referred to Board of Governors]

Legislative Session of the House of Delegates

RESOLVED, That a meeting of the House of Delegates be held several months prior to the convening of the annual regular session of the Florida Legislature, and that such meeting be called in addition to or in lieu of the annual meetings of the House of Delegates which currently are held in conjunction with the scientific program, be it further

RESOLVED, That the pre-legislative session of the House of Delegates be held in conjunction with the Annual Conference of County Medical Society Presidents and Secretaries.

Resolution 72-27
AMA Constitutional Convention

Everett Shocket, *Delegate*

Resolution 72-27 was not considered by the Reference Committee as there was no sponsor present at the Reference Committee Hearing.

Resolution 72-29
Public Relations Program
Dade County Medical Association

The Reference Committee considered Resolution 72-29 and noted that a similar program on a larger scale recently sponsored by the AMA had proved to be expensive and of questionable effectiveness, and for this reason recommended that this resolution not be adopted.

Resolution 72-29 was not adopted.

Dr. Clay: "I wish to thank the members of the Reference Committee, Truett H. Frazier, William W. Thompson, William W. Trice Jr., and Norman F. Coulter, and the secretary, Mrs. Mary Kay Samorisky, who worked so diligently.

"Mr. Speaker, this concludes the report of Reference Committee No. III."



Gov. Reubin O'D. Askew is greeted by FMA President Floyd K. Hurt, M.D., Jacksonville, as the Chief Executive steps to the lectern to present the Baldwin Lecture.

Report of Reference Committee No. IV
Legislation and Miscellaneous

Dr. Louis C. Murray, Chairman, presented the report of Reference Committee No. IV, Legislation and Miscellaneous.

Council on Legislation and Public Agencies

The report of the Council on Legislation and Public Agencies was reviewed by the Reference Committee which recommended that this report be approved as published including the recommendation of the Committee on Government Programs at the end of the report.

It was adopted.

Council on Legislation And Public Agencies

PHILIP B. PHILLIPS, *Chairman*

Most of the work of the Council on Legislation and Public Agencies is accomplished through the activities of its three major committees: Committee on State Legislation; Committee on National Legislation; and Committee on Government Programs.

Therefore, the report of your Council is hereby submitted as the individual reports of the three major committees.

Committee on National Legislation.—As most FMA members are aware, this Committee consists of the key contact physicians for each member of the Florida Delegation in the U.S. Senate and the U.S. House of Representatives.

Members of this Committee have kept in close touch with their assigned Senators or Congressmen on national legislative matters of interest to FMA and the American Medical Association.

A highlight of the Committee's activities was the annual Congressional Visitation which was held in March in conjunction with the Annual AMA-AMPAC Public Affairs Workshop in Washington, D.C.

In most cases, FMA has enjoyed a good working relationship with its Senators and Congressmen. As a result of Florida's growth as reflected officially in the 1970 census, our State will pick up three additional congressmen, and it is hoped that FMA will be able to establish good rapport with these individuals, whoever they may be.

Committee on State Legislation.—The committee has had another active year with responsibilities for coordinating all state legislation for the Florida Medical Association and recognized medical specialty groups. Two formal meetings of the committee have been held along with many informal conferences among committee members as items of an urgent nature arose. The committee is particularly pleased with the results of the Legislative Seminar, which was held in connection with the annual Conference of Presidents and Secretaries of County Medical Societies in Orlando, January 30, 1972. This conference was highlighted by an excellent address by Congressman Paul Rogers of Florida's Ninth Congressional District.

Consistent with the policies developed by the FMA House of Delegates, the committee worked closely with the Board of Governors in developing a legislative program for the 1972 Session of the Florida Legislature.

The following items summarize the phases of the committee's activities:

1. **Capital Office**—The Capital Office has continued to function under the supervision of Mr. Donald S. Fraser Jr., Director of the Public Affairs Department of the FMA. Additional part-time assistance was used while the Legislature was in session, not only to assist in the operation of the Capital Office, but to provide close liaison with the physician serving as "Doctor of the Day." Increased emphasis was placed on using the resources of the Capital Office to provide better service and coordination for the various medical specialty groups.

2. **The Capital Dispensary**—The committee has continued to place major emphasis on working with the Capitol Dispensary, which has proved to be most important in meeting the medical needs of legislators and their staffs. The critical shortage of space in the Dispensary has been partially alleviated by the additon of another room. Mrs. Delma Hart, R.N., has continued to provide immeasurable assistance to the FMA in coordinating the activities of the Dispensary with the "Doctor of the Day" program.

3. **Key Contact Physicians**—The Committee on State Legislation has continued to emphasize the need to develop



Sanford A. Mullen, M.D., Jacksonville (standing) recaps the activities of the Committee on State Legislation for the benefit of Reference Committee IV (Legislation and Miscellaneous). Louis C. Murray, M.D., Orlando (to right of lectern), presided at the hearing. Serving with Dr. Murray on the Committee were (left to right): John C. Fletcher, M.D., Tampa; Charles J. Kahn, M.D., Pensacola; Daniel L. Seckinger, M.D., Miami; and William M. Straight, M.D., Miami. Mrs. Helen Jones was the recorder.

a good key contact physician program in each county medical society in the state. This program continues to be the cornerstone upon which a successful legislative program is built.

4. Publications—The Legislative Bulletin was published every week during the Legislative Session and periodically between sessions. The Bulletin is designed to give up-to-date information to members of the FMA who are involved in the legislative activities. A pamphlet entitled "FMA Legislative Objectives—1972" was prepared by the committee, primarily for distribution to members of the Florida Legislature.

A similar publication was prepared for the 1971 Session of the Legislature. The two issues of the pamphlet have been well received. The committee will undoubtedly prepare such pamphlets for each future legislative session.

5. 1971 Legislative Accomplishments—During the 1971 Legislative Session, there were 186 legislative proposals that required the action of the State Legislative Committee or the Capital Office staff. Matters of major interest to the Florida Medical Association were:

—Passage of legislation which reduces the statute of limitations in medical malpractice actions from four to two years;
—Defeat of the chiropractic mandatory insurance coverage bill;
—Prevention of inclusion of chiropractors in Medicaid.

6. Major Legislative Objectives for 1972 Session—The major legislative objectives for the 1972 session of the Florida Legislature as established by the FMA House of Delegates and the FMA Board of Governors were:

—Passage of legislation which would assist in the development of hospital and medical society review committees by providing protection to the physicians who serve on these committees.
—Reform of Florida's abortion law.
—Passage of legislation to provide for the fluoridation of public water supplies of the State under the jurisdiction of the Division of Health.
—Prevention of passage of legislation which would encroach upon the ability of the Division of Health to perform its role in protecting the public health.
—Concern that any legislation with regard to Health Maintenance Organizations should not interfere with the private practice of medicine and should contain quality controls that would insure delivery of quality medical care through these mechanisms.
—Passage of legislation which would require chiropractors and all other practitioners of the healing arts to be graduates of colleges or universities that are accredited by an agency recognized by the U.S. Office of Education and the National Commission on Accrediting.
—Reinstatement of the physicians' exemptions from serving on jury duty.

A supplemental report will be prepared by the Committee on State Legislation and distributed prior to the first session of the House of Delegates. This supplemental report will outline progress made during the 1972 Legislative Session relative to the FMA state legislative program. It will also include other important state legislative items which might develop prior to the FMA Annual Meeting.

Committee on Government Programs.—Perhaps the most outstanding accomplishment of the Committee on Government Programs in the past year has been to serve as FMA's source of input into the Florida Department of Health and Rehabilitative Services.

Secretary Emmett Roberts, of the Department of Health and Rehabilitative Services, and key members of his staff, met with this committee in Tallahassee on September 18, 1971. In a presentation to the committee, Secretary Roberts expressed the desire to establish with FMA a relationship of "informality and mutual trust". He listed a number of ways in which the FMA could be of assistance to his Department, including the matter of medical services at Raiford Prison and other state institutions.

Subsequently, your committee sought and received the permission of the Board of Governors to act as the primary channel of communication between FMA and the Department of Health and Rehabilitative Services. In recent months, your chairman has had a number of meetings with Secretary Roberts in which subjects of mutual concern were discussed.

During one of these meetings, FMA's offer of the services of its appropriate committees to evaluate the medical services of the state "Divisions of Adult and Youth Corrections" was presented to Secretary Roberts, and the proposal was well received. Your committee understands that the FMA Council on Medical Service is following up on this proposal.

Secretary Roberts also was approached with the offer to place at his disposal in an advisory capacity FMA's Ad Hoc Committee on Drug Abuse. The committee has grown to about 20 members, and it was felt that an advisory group of about five would be more workable. This suggestion has been referred to the chairman of the Drug Abuse Committee.

The Chairman of the Committee on Government Programs also has been in touch with Secretary Roberts and other officials of his department regarding the funding of the Medicaid Program. The chairman also presented information on this subject to legislative committees.

Officials of the Department of Health and Rehabilitative Services attending the committee's meeting in addition to Mr. Roberts were Deputy Secretary Damon Holmes; Mr. E. Douglas Endsley, Director of the Division of Family Services; Wilson T. Sowder, M.D., Director of the Division of Health; Mr. Craig Mills, Director of the Division of Vocational Rehabilitation; and A. E. Ogden, M.D., Medical Consultant to the Division of Vocational Rehabilitation. Mr. Roberts expressed the hope that the committee will meet in the future with the directors of his other divisions.

The committee took action on several referrals from the House of Delegates via the Board of Governors, and its recommendations were reported back to the Board at a previous meeting. These included Resolution 71-24 (Medicare Program Benefits); Resolution 71-25 (Medicare Ostomy Irrigation Equipment); and the matter of inspection services of milk, food and hazardous substances by nonhealth agencies of government.

RECOMMENDATION

1. **That the Committee on Government Programs continue to be the Florida Medical Association's primary point of contact with the Department of Health and Rehabilitative Services; and that all initial contacts with that department concerning programs, surveys, studies, etc., be through this committee.**

Supplemental Report
Committee on State Legislation

Reform of Florida's Abortion Law—The Reference Committee recommended that the Board of Governors appoint the appropriate committee to develop guidelines and criteria for the implementation of the abortion law as it pertained to the use of medical facilities.

It was adopted.

Suggested Priorities for 1973—The Reference Committee reviewed the suggested priorities for 1973 as outlined by the Committee on State Legislation, in the area of medical legislation and recommended that this portion be amended by adding the words "adequate Medicaid funding" at the end of the paragraph.

The amendment was adopted.

With reference to the first priority listed, professional liability, the Reference Committee discussed at length the serious problem in the area of professional liability and the current plans of the Committee on State Legislation to obtain passage of legislation which would improve this situation. The Reference Committee recommended that efforts be made to investigate all possible mechanisms to alleviate this problem.

It was adopted.

Due to the need to develop priorities in the area of legislation and the fact that the Committee on State Legislation cannot possibly cover the amount of legislation of interest to physicians introduced each legislative session, the Reference Committee recommended that communication between the members of the FMA staff, the Committee on State Legislation, the Council on Specialty Medicine, the members of the specialty groups and individual members of the Florida Medical Association be encouraged.

It was adopted.

The Reference Committee further recommended that each specialty group must be certain that its aims do not conflict with established FMA policy in order that its legislative interest can be better served and coordinated within the framework of FMA policy.

The recommendation was adopted.

The Supplemental Report of the Committee on State Legislation was adopted as amended.

Supplemental Report Committee on State Legislation

SANFORD A. MULLEN, *Chairman*

The purpose of this supplemental report is to outline the final actions of the Florida Legislature in the field of health legislation. This report is divided into three parts. These parts include a summary of action on major legislative objectives of the Florida Medical Association for the 1972 Legislature, a summary of other major legislation in the health field, and recommendations for the 1973 Legislature.

The Chairman of the Committee on State Legislation, Sanford A. Mullen, M.D., and the Director of Public Affairs, Donald S. Fraser Jr., will attend the reference committee meeting to participate in discussions on these various items.

ACTION ON MAJOR LEGISLATIVE OBJECTIVES OF THE FMA FOR 1972 LEGISLATURE

1. Enactment of Laws to Assist the Development of Hospital and Medical Society Review Committees:

 A. Immunity From Liability for Members of Hospital and Medical Society Review Committees (HB 3122)—This bill exempts members of review committees of hospitals and local and state medical societies from liability as a result of their actions while serving on these committees. The bill became law as a result of the Governor signing it on March 16, 1972.

 B. Protection of the Records of Hospital and Medical Society Review Committees From Subpoena (SB 565/HB 3163)—The Legislature failed to enact these bills which sought to protect the records of medical review committees from subpoena. The Senate Bill (SB 565) passed favorably from the Senate Judiciary Committee but died on the Senate calendar. The House Bill (HB 3163) died in the House Judiciary Committee.

2. Reform of Florida's Abortion Law—Florida's abortion law was revised by the enactment of a therapeutic abortion bill (Committee Substitute for SB 284) by the 1972 Florida Legislature. This bill, which allows an abortion to be performed whenever there is reasonable medical indication of need, is in conformance with the FMA policy established by the House of Delegates in 1970.

 An extremely confusing and restrictive therapeutic bill was passed by the Florida Senate and was pending on the House calendar during the final days of the Session. It was only as a result of intensive activity on the part of the FMA staff, individual physicians and the physician members of the Legislature that agreement was reached to pass what many feel to be the best therapeutic abortion bill yet adopted by any state. The Committee on State Legislation recommends that the Florida Medical Association take the responsibility of establishing guidelines for the ethical impleplementation of this law by the physicians of Florida.

3. Fluoridation of Public Water Supplies (HB 1362/SB 259)—Legislation which would have provided for fluoridation of public water supplies under the jurisdiction of the Division of Health passed the House of Representatives but died on the calendar in the Senate.

4. Continuance of a Strong State Health Agency—Several proposals were advanced, primarily in the area of environmental reorganization and inspection of hotels and restaurants, which would have diluted the ability of the Division of Health to carry out in an effective manner its role in protecting the public health. Success was achieved in preventing the passage of any legislation which would have resulted in diluting the effectiveness of the Division of Health.

5. Health Maintenance Organizations—The general objective of the committee in the area of Health Maintenance Organizations was to make sure that any legislation enacted would not interfere with the private practice of medicine and contained reasonable quality controls to insure delivery of quality medical care through any health maintenance organizations that might be established. The legislation which passed (SB 498) was in keeping with this overall objective and conformed to FMA policy on Health Maintenance Organizations as established by the Board of Governors.

 In the initial stages of the development of this legislation, efforts were made to require that contracts which a Health Maintenance Organization has with private physicians must be approved by the State of Florida and that the individual physician's office records (both fiscal and medical) would be open to inspection by the state. As a result of intensive effort by the FMA staff and key contact physicians, these proposals were defeated.

6. Accreditation of Health Practitioners (SB 505/HB 3123)—This legislation would have required chiropractors and other practitioners of the healing arts to be graduates of colleges or universities that are accredited by an agency recognized by the U.S. Office of Education and the National Commission on Accrediting.

 The Senate Bill (SB 505) passed favorably from the Senate but died in the House Committee on Manpower and Development, along with the companion House Bill (HB 3123).

7. Physician's Exemption from Serving on Juries (SB 514, 291/HB 2877, 2855)—The Senate Bills passed favorably from the Senate Committee on Judiciary-A but died on the Senate calendar. The House Bills died in the House Committee on Judiciary. This proposed legislation incurred a great deal of opposition, particularly from the lawyer legislators, who happen to be a majority of the membership of the House Judiciary Committee.

OTHER SIGNIFICANT LEGISLATION OF MEDICAL INTEREST

1. Legislation Which Would Be Detrimental to Quality Health Care—Opposed by the FMA

 A. Sales Tax on Medical Fees (HB 3121)—Would have placed a 4% sales tax on physicians' fees. Died in House Finance and Taxation Committee.

 B. Generic Drug Substitution—Would have required that all prescriptions be written by generic name and allowed for substitution of generic equivalents by pharmacists if requested by the patient (HB 3639). Died in House Committee on Health and Rehabilitative Services.

 C. Psychologists' Insurance Coverage (HB 3513/SB 1030)—Would have required that all insurance companies provide coverage for psychologists' services whether the company now provides payment for emotional disorders or not; also would have prohibited distinction between in-patient and out-patient coverage for emotional disorders. The Senate Bill was killed in the Senate Commerce Committee; the House Bill was so watered down by amendments in the House Insurance Committee that proponents let it die on the House calendar.

 D. Chiropractic Insurance Coverage (CS HB 852)—Would require all insurance companies to provide coverage for chiropractic services. This bill, which was substantially amended by the House Insurance Committee, died on the House calendar.

 E. Consumer Directors for Blue Cross-Blue Shield (HB 4405)—Would require that the majority of the members of the board of directors of Blue Cross and the board of directors of Blue Shield be members of the consuming public not in any way connected with a provider of health care. Died on the House calendar.

 F. Licensure Reciprocity—Several proposals were defeated which would have allowed for reciprocity for physicians licensed in other states.

2. Significant Health Legislation Adopted in 1972 Not a Part of Basic FMA Legislative Program

 A. Certificate of Need (HB 3152)—This bill, which was favorably passed by the 1972 Session, requires that before any additional or new construction can be begun on any health facility, a certificate of need study must be completed. While the certificate of need study must be completed prior to construction, the Division of Health is not bound by the findings of the certificate of need study before it may issue any license required for additional or new hospital or other medical facility construction. Attempts were made to make the results of the certificate of need study binding upon the Division of Health in their issuance of a license, but these were defeated in large measure due to the opposition of the FMA to such a provision. The bill as adopted is in conformance with FMA policy as adopted by the Board of Governors.

 B. Emergency Treatment of Minors Without Parental Consent (SB 307)—This law, which was supported by the FMA, allows for treatment of minors without parental consent in emergency situations under certain specified conditions.

 C. Waiver of ECFMG Under Specific Conditions (SB 165)—This law waives the requirement that a foreign graduate must have passed the ECFMG in order to qualify to take the Florida Board of Medical Examiner's Examination, if he is board certified.

 D. Certification of Physician Trained Mobile Rescue Paramedic (SB 677)—This law provides the procedure whereby the Division of Health certifies physician trained mobile rescue paramedics provided they have met certain prescribed training courses.

 E. Requirement that all Disability Policies Include Coverage for Newborns (HB 3460)—This bill requires that every disability policy delivered after August 1, 1972, which provides coverage for newborn children, must do so from the date of birth.

 F. Comprehensive Family Planning Act (SB 413)—This bill establishes a comprehensive family planning program under the jurisdiction of the Department of Health and Rehabilitative Services. The program to be established is not restricted to the indigent.

 G. Revisions of the Drug Abuse Program Under the Department of Health and Rehabilitative Services (HB 4288)—This law makes revisions to the current drug abuse law, including denial of a license to a methadone dispensing station which does not provide rehabilitative services. The primary provision of the law is the section which allows minors to obtain rehabilitative or medical treatment for drug abuse or dependency without parental consent. This measure was supported by the FMA.

3. Legislative Apportionment and Congressional Redistricting—The twin issues of legislative apportionment and congressional redistricting, as everyone in Florida



Mrs. Wesley S. Nock, Coral Gables, retiring President of the Woman's Auxiliary to the Florida Medical Association, affixes the President's Pin, to the blouse of her successor, Mrs. James DeVito, St. Augustine.

is aware, kept the Legislature fully occupied for a prolonged time before final agreement was reached. The action is still subject to court review and could possibly be overturned or modified.

The plan for apportionment of the Legislature is very complex, particularly in the case of the House. The details of the plan have been widely publicized in the news media. Copies of the apportionment plan have been prepared for distribution to county medical societies.

SUGGESTED PRIORITIES FOR 1973

The Committee on State Legislation, through its Capital Office, had active involvement in 233 individual items of legislation during the 1972 Session. The committee has come to the inescapable conclusion that it can continue to be effective only if its efforts are limited to those items of major importance to the Florida Medical Association. The committee feels that it should develop a list of priorities for approval by the Board of Governors, in keeping with the policies established by the House of Delegates. The Committee on State Legislation has under active consideration priorities for recommendation to the Board of Governors in the areas of professional liability, chiropractic, health services organization and adequate Medicaid "funding."

FINAL COMMENT

The Committee on State Legislation wishes to express appreciation to the members and staff personnel of all county medical societies for their cooperation in carrying out the objectives of the FMA legislative program.

The Reference Committee commended Sanford A. Mullen, M.D., Chairman of the Committee on State Legislation, and Donald S. Fraser Jr., Director, FMA Public Affairs Department, for the excellent job that they have done in the face of oftentimes very difficult circumstances.

Report of Board of Governors

Referral by 1971 House of Delegates
Resolution 71-22
Kidney Dialysis

The Reference Committee reviewed the Board of Governor's report on Resolution 71-22, Kidney Dialysis, that appropriate legislation in this area had been enacted. The Reference Committee felt that no further consideration of this matter was necessary and recommended that this report be filed for information.

It was filed for information.

(See Board of Governors Report, page 58.)

Council on Legislation and Public Agencies
Supplemental Report (1971)
Needle and Syringe Legislation

The Reference Committee recommended that this proposal be disapproved, as recommended by the Board of Governors.

It was disapproved.

(See Board of Governors Report, page 58.)

The Reference Committee further recommended that the matter of needle and syringe legislation remain under study and be once again referred to the Board of Governors for appropriate in-depth study of alternate methods of control, such as consideration of mandatory registration legislation and other such methods of implementation for control.

It was adopted and referred to the Board of Governors.

Resolution 72-3
Exemption of Physicians from Jury Duty
Alachua County Medical Society

The Reference Committee submitted a substitute for Resolution 72-3, Exemption of Physicians from Jury Duty, and recommended that it be adopted.

Substitute Resolution 72-3, Exemption of Physicians from Jury Duty, was adopted.

Substitute Resolution 72-3

Exemption of Physicians from Jury Duty

RESOLVED, That the Florida Medical Association endorse the need for legislative changes to establish a fair mechanism to exempt physicians from serving on juries in those instances where the health care of the patient may be compromised.

Resolution 72-18
Medicaid Funding
Pinellas County Medical Society

The Reference Committee submitted a substitute for Resolution 72-18, Medicaid Funding, and recommended that it be adopted.

Substitute Resolution 72-18, Medicaid Funding, was adopted.

Substitute Resolution 72-18

Medicaid Funding

RESOLVED, That the Florida Medical Association's Board of Governors undertake an indepth study of the specific deficiencies of the current Florida Medicaid program and recommend a revision of the current law to provide proper funding of all aspects of medical care for the indigent.

Dr. Murray: "Your chairman wishes to thank the members of this committee, Drs. Charles J. Kahn, William M. Straight, Daniel L. Seckinger, and John C. Fletcher, the members who came to speak before the committee and the secretary, Mrs. Helen Jones, without whose efforts, cooperation and assistance this report would not have been possible."

"Mr. Speaker, this concludes the report of Reference Committee IV."

Report of Reference Committee No. V
Medical Economics

The Vice Speaker assumed the Chair and called for the report of Reference Committee No. V, Medical Economics.

Dr. Thad M. Moseley, Chairman, came forward to present the report of Reference Committee No. V, Medical Economics.

Council on Medical Economics

Upon recommendation of the Reference Committee the report of the Council on Medical Economics was adopted as presented.

Council on Medical Economics

VERNON B. ASTLER, *Chairman*

Various committees of the Council on Medical Economics have been quite active during the past year.

The Committee on Hospitals and Extended Care Facilities has cooperated in two workshops in association with the Joint Commission on Hospitals and the Florida Hospital Association. Workshops were held in January in Miami and Winter Park, Florida, with an additional meeting scheduled on March 18, 1972, for trustees, medical staff and administrators, because of the favorable response to the previous two workshops held in January. Adequate notice has been sent to all hospitals and placed in the bulletin of the FMA concerning this meeting. This Committee, through its chairman answered numerous inquiries during the year, copies of which have been forwarded periodically to FMA headquarters concerning hospital problems and hospital-physician problems. The Committee has also studied a hospital discharge abstract system designed primarily to assist medical staff utilization and audit committees. This system has been endorsed in Pennsylvania by the Medical and Hospital Association and has approximately 130 participating hospitals. It was recommended by the Committee that this was a useful program but that FMA should not sponsor one particular program but should merely obtain a position of no objections to such a program being considered by Florida hospitals or medical staffs. A review of the model bylaws for hospitals was attempted this year but no changes were recommended. It was felt that these revisions would be necessary in the forthcoming year.

The Committee on Relative Value Studies worked extremely hard during the year of 1971 and completed total revision and updating of the 1968 Relative Value Studies. This new manual was finally approved by the Board of Governors in October, 1971, with printing and release expected in February, 1972. This Committee plans an additional meeting in the spring before the annual FMA meeting to update changes and other matters. This Committee certainly deserves a vote of thanks to its chairman and members for a difficult job well done.

The Committee on Computerization in Medicine, taken over by Dr. Turner, met in January of 1972 in Orlando, making extensive recommendations concerning emergency medical communications which are still under consideration by the Council. The Committee has continued to work with Dr. Phil Hampton and has reviewed his computer program with Mr. George Zobrist as consultant. This Committee will also meet at the time of the annual meeting in May.

The Committee on Advisory to Blue Shield and Fiscal Intermediaries has filed a report, following meetings chaired by Dr. Fitzpatrick, which is included at the end of the Council's report.

Dr. Myers' Committee on Health Insurance has been active, having met on two occasions and planning a meeting during the annual meeting in May.

Committee on Hospitals and Extended Care Facilities—The Committee was called on through the year to act or comment on the following items:

JCAH Seminars—A JCAH Workshop Seminar was held in Winter Park on January 13-14, 1972. A report was filed with the Council. Subsequently, a one day meeting was scheduled at Orlando on March 18 exclusively for trustees, medical staff, and administrators. This was planned because of the favorable response to the workshop held in January. Brochures were sent to all hospitals and a notice was placed in the bulletin of the FMA.

Inquiries—Correspondence from the Chief of Staff of DeSoto Memorial Hospital regarding surgical assistants as required in the bylaws of that medical staff was referred for an opinion by legal counsel. The Committee also considered and responded to a letter from Everglades Memorial Hospital concerning recording of portions of the patient's history for the hospital records by someone other than the physician.

H.U.P.—This is a Pennsylvania-based hospital discharge abstract system designed primarily to assist medical



Thad Moseley, M.D., Jacksonville (standing), served as Chairman of Reference Committee V (Medical Economics). Other members of the Committee were (left to right): Robert F. Dickey, M.D., Miami; Charles F. Tate Jr., M.D., Miami; Robert L. Andreae, M.D., Fort Lauderdale; and James M. Stem, M.D., Clearwater. Mrs. Mary Tai White recorded the proceedings.

staff utilization and audit committees. It has been endorsed by both the medical and hospital associations of that state and presently has 130 participating hospitals in Pennsylvania and adjoining states. H.U.P. is also a founding member of the American Association of Health Data Systems, a nonprofit corporation of some ten regional systems.

The H.U.P. requested review of its plan before it received applications from Florida hospitals for (1) approval by FMA, and (2) to determine if H.U.P. would be in conflict with any of FMA's present or contemplated plans in this field.

After review by the committee chairman of the descriptive manual, it appeared that no plan now existing or contemplated would conflict with a hospital participating in H.U.P. It is not suggested that the FMA should endorse one such plan over another, nor express approval or disapproval; but, merely state that it has no objections to such a program and that a hospital considering such a plan should do its own investigation to determine the efficacy and need of said program.

Revised Nursing Home Rules—The Committee considered the Proposed Rules of the Florida Department of Health and Rehabilitative Services, Division of Health, Medical and Related Fields, Chapter 100-29—Nursing Homes and Related Facilities Licensure. The main issue of consideration was definition of "intermediate care facility (ICF)." Physicians should be notified of such facilities and familiarized with the rules after they have been finalized by the Division of Health.

Model By-Laws—The model by-laws as revised by the Committee last year were reviewed. No changes were attempted this year. Due to recent developments in utilization review, peer review, statutes regarding liability, etc., some revision will have to be made this coming year.

Committee on Relative Value Studies.—The Committee on Relative Value Studies worked diligently through 1971 on extensive revision and updating of the 1968 Relative Value Studies. Meetings and conferences were held at frequent intervals throughout the year, and committee work on the new manual was completed in late 1971. The Council on Specialty Medicine reviewed the manual in September and October, 1971, with approval and a specific charge that the Committee undertake continuing prompt revision and updating of procedures and relative values. The Board of Governors gave final approval to the manual at their October 1971 meeting, including format, CPT terminology and coding, and other changes not present in former studies. Printing and release of the new 1971 Relative Value Studies was completed in February 1972.

It is the hope of the Committee that the 1971 studies will be a highly useful guide to Florida physicians and third party interests in describing and coding procedures clearly and adequately, and as an aid in working out fee structures. The Current Procedural Terminology of the AMA has been used for the first time as a basis for the augmented 1971 manual and provides a thorough and complete terminology which has not been available before.

The Committee will hold a further meeting in the spring before the FMA Annual Meeting to make corrections in the manual and to get underway studies which will lead to necessary revisions in 1972. Physicians of Florida are urged to communicate with the Committee through FMA in regard to changes in relativity which they feel are indicated. The terminology and coding will, in the future, be drawn from Current Procedural Terminology, Second and Third Editions, and will keep pace with CPT changes.

Committee on Advisory to Blue Shield and Fiscal Intermediaries.—The Committee on Advisory to Blue Shield and Fiscal Intermediaries began the year with some pall cast over its activities by: (1) dissatisfaction with Blue Shield expressed at the House of Delegates meeting in May, 1971, (2) rumor that the Committee of Seventeen was to be disbanded and, (3) by criticism heard in certain quarters that the Committee of Seventeen as well as the Blue Shield Board of Directors were mere rubber stamps for Blue Shield itself.

At the first meeting of the Committee of Seventeen held in Jacksonville on the 25th of September, these criticisms above mentioned were thoroughly discussed and the Committee was reassured of the necessity for its continued existence by statements rendered by Floyd K. Hurt, M.D., President of FMA, Robert E. Zellner, M.D., new Chairman of the Board of Directors of Blue Shield, and Warren W. Quillian, M.D. Based upon encouraging remarks rendered by these leaders in Florida medicine, we then directed our activity to revivifying the Committee of Seventeen. We felt that more meetings were indicated to discuss the many problems that arise, that the activities of the Committee had to be made known to the membership at large if we were to regain confidence of the doctors in this Committee of the Florida Medical Association. To effect these matters, the Committee felt that we had to have secretarial help, and we requested this of Blue Shield. Subsequently, Mr. Michael S. O'Farrell was appointed to this task, by Blue Shield, based upon a written agreement between Blue Shield and Florida Medical Association as to the duties and responsibilities of such a representative. We discussed forwarding to all the doctors in the state brief summaries of the minutes of our meetings so that they could be kept informed and requested they write to us for help with any problems that arose. We also discussed other methods by which pertinent information relative to Blue Shield and the activities of the Committee of Seventeen could be published in either letter form or articles in the Florida Medical Association Journal.

With this auspicious start, we then ran into a roadblock of setting up further Committee meetings because of inadequate staffing, apparently at Florida Medical Headquarters. Since it is customary for somebody from FMA Headquarters to attend Florida Medical Association committee meetings, there is an obvious shortage of weekends and/or FMA personnel to do this adequately.

This Committee, for example, wished to meet again in November, but roadblocks prevented this until January. The Committee of Seventeen suggested that these problems might be circumvented by: (1) increased staff at FMA or, (2) developing a master time schedule for Committees and Councils to meet during the course of the year. Thus, if meetings were scheduled sufficiently far ahead of time, other days in the week could be chosen rather than weekends.

The Committee of Seventeen held its next meeting on the 9th of January in Orlando and has another meeting scheduled for the 5th of March in Tampa. The Chairman will also suggest to the Committee that they take advantage of the yearly meeting of the Florida Medical Association to hold a breakfast meeting as they did in years past.

Mr. Michael O'Farrell from Blue Shield has been a great help in setting up our meetings, getting material distributed to the Committee members, etc. He has begun a program of circuit riding to the Committee members between meetings to discuss possible subjects for our agenda that may exist in various districts of the Florida Medical Association. I, therefore, feel that this Committee has developed a new sense of direction, a reaffirmation of its need to continue in existence. A program of keeping in contact with fellow physicians throughout the state has begun. The resolutions and recommendations made at the September 1971 and January 1972 meetings were submitted to the Board of Governors and are being implemented. Some of these recommendations are presented below. Other routine matters not pertinent to all members of Florida Medical Association were carried out but are not included. If some quite pertinent and urgent matters arise at our March 5 meeting, we will forward a supplementary report to cover same.

RECOMMENDATIONS

1. **That there be a return to the old Committee of 17 page in the Journal of FMA as a means of dissemination of information.**

2. That the minutes of the committee meetings will be submitted in an abbreviated form to the practicing physicians in the State of Florida, also that physicians be reminded that they can contact committee members to present problems in the field of Blue Shield.

3. That we accept the offer of Blue Shield Board to provide tape recorder and recording secretary and appropriate representative to attend all meetings, that meeting minutes be abstracted and prepared for distribution, that FMA representative be assigned to the committee and Blue Shield representative be assigned to committee, and that the tape of the meeting be retained for subsequent review as needed.

Committee on Peer Medical Utilization Review.—The Committee on Peer Medical Utilization Review has held eight meetings during the year, the majority of these being three-day meetings. As can be expected from a program of this magnitude, the Committee has experienced the usual number of growing pains.

Most of the county medical societies now have operative PMUR committees, even though peer review remains in the minds of many members a controversial issue.

The Chairman announced at the Conference of Presidents and Secretaries a modification of the Social Security Administration's policy on suspension of payments for all physicians undergoing peer review. The new policy is essentially that physicians whose calculated refund is $4,000 or less will not have funds witbheld. If the calculated refund is $4,000 or more, the carrier will withhold only up to twice the amount of refund and release all other claims. The Committee feels that this is a significant step. This action was the result of the efforts of both the carrier and the Peer Review Committee.

The Committee has been advised on a number of occasions that the Social Security Administration is taking a close look at this approach to peer review, and it is felt by many officials within the Department of Health, Education and Welfare that this is the proper approach. The Committee, with the permission of the Board of Governors, had as its guests to observe for their information Thomas M. Tierney, Director of the Bureau of Health Insurance, HEW; Tbeodore C. Bedwell, M.D., Chief Medical Officer, HEW; and Douglas M. Richard, Regional Representative, Bureau of Health Insurance, HEW.

Furthermore, so that some influence might be brought into the HR-1 legislation before Congress, the Honorable Wilbur G. Mills and Honorable Sam M. Gibbons were invited to attend a meeting of the Committee.

The following is a report of the Committee's activities for the year: (May 1971 through March 1, 1972, plus an estimation for the period 3/1/72-5/1/72).

New cases received from Blue Shield	139
Cases still out to county medical societies	106
Total Reviews	113
Estimated new cases from BS to 5/1/72 (by BS)	50-60

SUMMARY OF REVIEWS:

Concurred with county over-utilization	35	
Concurred with county—state had to set %	9	
Concurred with county on OU—cbanged %	5	down
	1	up
Concurred with county—No OU	22	
Disagreed with county		
County said OU—state said No OU	1	
County said No OU—state said OU	18	
Referred back to county	18	
Requested physician to appear	4	

SUMMARY OF APPEALS:

Total number of appeals		36
Same OU	17	
Less OU	15	
No OU	4	

Appeals pending for April meeting as of March 1, 1972: 9
Reviews pending for April meeting as of March 1, 1972: 20

The area in which the Peer Medical Utilization Review Committee is confronted with greatest frequency is the deviation from norm within the hospital, primarily excessive number of hospital visits.

Committee on Health Insurance.—Tbis is a preliminary report on the activities of the Committee on Health Insurance of the FMA. Our initial meeting was held in November 1971, at which time certain ground rules were laid down concerning the activities of this Committee and what we hoped to accomplish. In addition, we reviewed five or six cases that had been pending from the previous year and rendered opinions concerning the fees charged in each of these several cases.

In discussing the overall purpose of this Committee, we felt that we would, if possible, follow the recommendations of the local review committee, but as each case was discussed, it was apparent that this guideline could not be followed entirely. The concept of varying fees for the same procedure in different regions of Florida was agreed upon by the Committee as a general principle. However, as further discussion of the cases evolved, it became apparent that there was such a wide variation of fees from one section of the state to another that this concept could not be accepted in total. As an example, it was felt that in the lower East Coast the cost of living, office expenses, etc. was probably greater than the Pensacola region, but we certainly did not feel that, for instance, one procedure done in the Miami area was worth twice as much as the same procedure in some other region of the state. It was felt by the Committee that a little more definite guidance by the FMA would make it easier for this Committee to arrive at reasonable solutions for the various cases presented to this Committee.

Since the initial meeting, several cases have been presented to each of the Committee members, and a mail vote in each of these cases was rendered, being sent back to staff. In several of these cases there was disagreement, so these—plus several other cases that have not been presented for our examination—will be taken up at our next meeting, March 25, 1972.

Committee on Members Insurance.—The Chairman called a meeting of the Committee during the Florida Medical Association's Annual Meeting in May 1971. Those members of the Committee who were in attendance at the Annual Meeting were present. The purpose of this meeting was to consider the recommendation to transfer the Accidental Death and Dismemberment plan from the Insurance Company of North America to Continental Casualty, and to approve the recommendation that the Continental Casualty Company offer to the membership an excess major medical plan which would implement the basic Catastrophe plan. The Committee was asked also to consider the necessity to increase the premium on Catastrophe Hospital plan. Their experience has shown that it was necessary to raise the premium or to modify the benefits. These recommendations were forwarded to the Board of Governors for consideration at their May 9, 1971, meeting.

Even though the Committee has not met as a group, a number of items have been circulated to the members for study. The study is continuing on such items as the following:

(1) Life insurance program proposed by the Voyager Life Insurance Company.
(2) Automobile insurance program for the membership.
(3) Life insurance program proposed by ITT Hamilton Life Insurance Company for the medical association, primarily geared to the dependents.

The Committee wishes to reiterate its purpose and goals of working with the administrators of the insurance program to ascertain that we have the most up-to-date and comprehensive programs available for the money invested.

Committee on Professional Liability Insurance.—The Committee held two meetings during the year, on September 26 and December 12. The actions of those meetings have been forwarded to the Board of Governors and therefore are not shown in this report.

In addition to these two meetings, the Committee has been active in meeting with county medical societies and hospital medical staffs to explain the program. The chairman has taken an active part in these programs, explaining the Association's role in the professional liability program. It is the feeling of the chairman that these roles play a vital part in the education of the Association members in this extremely difficult to understand area. The chairman furthermore would like to encourage county medical societies to include this as part of their program during the up-coming year's schedule.

The Committee feels that you should be advised of the problems which have faced it relative to this program. In July the administrator was denied the privilege of providing a binder for all new applicants coming into the program. The early part of August the company advised the Executive Vice President of the Association that, based on the experience of the past year, the program could expect a rate increase effective January 1, 1972. On September 26 the Committee and the company reached an agreement on the method of handling new applications, declinations and non-renewals. This provided for a professional liability insurance review by the county societies prior to any action. At the December 12 Committee meeting, it became apparent by way of discussion that with the time remaining prior to January 1 renewal, it was impractical to continue with the prior agreement so this was modified for certain cases. The latter part of December physicians were being advised that their coverage would no longer be continued with an effective date of January 1. In most cases, this provided the physician five or less days to obtain additional coverage. As late as January 17, physicians were being advised that they would no longer be covered and this action was retroactive to January 1. Needless to say, the retroactive non-renewal of physicians under the program created a tremendous problem. On February 18 officers from Employers-Commercial Union Companies met with the executive staff, broker and administrator and these problems have been ironed out. Assurance has been given that an occurrence such as took place in late December and early January will not occur in the future.

Future plans of the Committee involve steps that will assure a new outlook relative to education and smoothness of operation.

Supplemental Report
Council on Medical Economics

Upon recommendation of the Reference Committee the Supplemental Report of the Council on Medical Economics was adopted as presented.

Supplemental Report
Council on Medical Economics

Committee on Advisory to Blue Shield and Fiscal Intermediaries.—

RECOMMENDATIONS

1. That Blue Shield conduct a study on the principle of UCR used in Blue Shield UCR contracts also applying to complementary coverage contracts and also study the cost of paying the $50 deductible.

2. That the Committee of Seventeen endorses the usual, customary and reasonable concept with the interim update procedure: customary (area allowances) to be updated once a year, automatically. Usual (personal profile allowances) to be updated once a year, automatically, and upon written notification once a year. A physician may send Blue Shield one letter any time during the year and change up to ten of his fees. If these fees fall at or below the customary (area allowance), they will be allowed within sixty days. The Committee of Seventeen will continue to study usual, customary and reasonable fee program.

On March 21, 1972, the Bureau of Health Insurance finally approved the compromise recommendation of the Committee of Seventeen for additional wording on the explanation of Medicare benefits. This letter allows us to add the words, "This payment does not necessarily cover the physician's entire fee" in the remarks section of the EOMB for unassigned claims. This wording will not take the place of "more than allowable charge" but will supplement it when any portion of a physician's fee has been disallowed. Blue Shield has stated that this change will be operational by May 1, 1972.

Resolution 72-11
Medicare Terminology—More Than Allowable Charge
Pinellas County Medical Society

The Reference Committee recommended that Resolution 72-11 be amended by deleting the first 'Resolved.'

A substitute motion was received that due to possible inaccuracies and for clarification this resolution be referred to the Board of Governors.

The substitute motion carried.

Resolution 72-11

[Not Adopted—Referred to Board of Governors]

Medicare Terminology—More Than Allowable Charge

RESOLVED, That the explanation of "more than allowable charge" as found below, be made available to Florida physicians through distribution facilities of FMA or Blue Shield of Florida, therefore, be it further

RESOLVED, That permission be granted to all physicians for duplication and distribution through their office of this explanation:

"More Than Allowable Charge"

The Medicare program has established a payment system for physician services. The phrase "more than allowable charge" which has appeared on many Medicare forms has been used to reduce Medicare payment and should be explained. This phrase does not mean your doctor has overcharged you.

On January 1, 1971, all Medicare payments were frozen on the basis of 1969 physicians' fees. Payments are based on the 50th percentile or median fee charged by the physician for that particular service.

The fee covered by Medicare cannot be higher than what 75% of the physicians in the area were charging in 1969.

Medicare then pays 80% of this amount. The amount paid therefore is always less than the amount charged. The phrase, "more than allowable charge" does not indicate that the fee was excessive or more than should be charged for that particular service. In fact, in some instances this may actually refer to a fee that is lower than what most physicians in the area would charge for the same service. His fees may especially be lower than when compared to the fees charged by physicians in other parts of the state.

It must be remembered that "more than allowable charge" does not indicate an excessive fee. If you have any question about Medicare, write your congressman.

Subcommittee on Workmen's Compensation

Upon recommendation of the Reference Committee the report of the Subcommittee on Workmen's Compensation was adopted as presented.

Subcommittee on Workmen's Compensation

JOSEPH G. MATTHEWS, *Chairman*

Effective February 15, 1971, a new fee schedule was put into force by the Workmen's Compensation Bureau, which raised the conversion factor from $5.50 to $6.00. Also there was a sixty percent increase in the values for initial office visits and follow-up office visits. This new fee schedule also permitted using anesthesia rules that had been adopted by the FMA back in 1968.

In March of 1971, the FMA petitioned the Bureau to have another hearing, so that evidence could be submitted showing that this most recent fee schedule still did not comply with the wording of the law. This hearing was held on April 21, 1971. At that time statistical material was introduced, under oath, showing that there were still gross inequities in the Medical-Surgical Fee Schedule, particularly relating to follow-up hospital visits and conversion factor for Anesthesiology. It was also shown the method of paying for physical therapy treatments in a doctor's office was not the same as for those services rendered in a physical therapist's office. It was also shown that the $6.00 conversion factor was still low. Several months went by and there was no response from the Bureau, and the Committee on Workmen's Compensation did contact the director and ask for a ruling. In October of 1971, the director of the Division of Labor did contact the committee and suggest Blue Shield fees might be adopted for use of workmen's compensation cases. Responding to this, the FMA completely rejected this proposal, stating in detail why it could not and would not work. In December, the director asked the FMA if they would submit recommendations for revision of the Medical-Surgical Fee Schedule, and this was promptly sent to the director, recommending increases in many of the items that were low, particularly follow-up hospital visits. Also an increase was recommended in the conversion factor for nonoperative care, anesthesia and surgery, as well as a fifty cent increase of conversion factor for radiology and pathology. The committee also recommended that the physical therapy charges be made the same for those in a doctor's office as those in a physical therapist's office. In March of 1972, a member of the committee had a personal interview with Mr. Slepin, the director, and was given verbal reassurances that the Bureau was working on the problem and felt there could be an interval adjustment of the Workmens' Compensation Fee Schedule in the near future.

It should be noted that during the freeze period, the committee did not feel that it was possible or appropriate to demand increases in the allowable fees.

The Committee also recommended to the director, that in the future they should strongly consider using the updated 1971 Relative Value Studies of the FMA for future fee schedules.

Board Action No. 53
Workmen's Compensation

The Reference Committee recommended that Action No. 53 of the Board of Governors, regardings the Ad Hoc Committee on Workmen's Compensation, be filed for information.

(New Workmen's Compensation Fee Schedule was approved May 2, 1972.)

It was filed for information.

(See Report of Board of Governors, page 62.)

Ad Hoc Committee on Health Maintenance Organizations

Upon recommendation of the Reference Committee the report of the Ad Hoc Committee on Health Maintenance Organizations was adopted as presented.

Ad Hoc Committee on Health Maintenance Organizations

JAMES L. BORLAND JR., *Chairman*

Your Ad Hoc Committee on Health Maintenance Organizations was organized during the past year to study the HMO concept and to report its findings and recommendations to the Board of Governors and the House of Delegates.

Specifically, your Committee was charged with studying Resolution 71-16, which was not approved by the House of Delegates in 1971 but was referred to the Board of Governors. Originally, the Committee consisted of six members, but it was enlarged later to include representatives of the medical schools of the University of Florida and the University of Miami.

As most FMA members are aware, the Health Maintenance Organization concept is being promoted with great fervor both nationally and here in Florida as an answer to virtually all problems in the health care delivery system.

Your Committee was asked by the Legislature to give advice and help develop regulatory bills for HMO's in Florida. Therefore, it was necessary for FMA to develop a position prior to the 1972 session of the Florida Legislature. It was also apparent that the Legislature, several of its committees, and other state government agencies had identified permissive and regulatory legislation as a priority item.

After two meetings in Orlando plus a telephone conference meeting, the Committee developed a position on HMO's which subsequently was approved by the Board of Governors. Within the framework of this policy, your Chairman and other members of the Committee have been invited to review and comment on several HMO bills, confer with members of the Legislature and testify at a

legislative hearing. Legislative contacts were carried out at the request of and in cooperation with the Committee on State Legislation.

Because HMO's and Foundations for Medical Care (which is the province of another committee) have many parallels, your Committee's discussions have touched on both. It has occurred to your Committee that inasmuch as basic HMO policy has been established, it would make for more efficiency if only one FMA committee were active in the matter of health care delivery systems. (See Recommendation No. 1).

RECOMMENDATIONS

1. That the Ad Hoc Committee on Health Maintenance Organizations be discharged and that in the future all matters concerning HMO's and experimental health delivery systems be referred to the Subcommittee on Foundations for Medical Care.

2. That the following statement be adopted in lieu of Resolution 71-16:

 "Resolved, that the Florida Medical Association expresses its agreement with the concept of considering pluralistic approaches to the delivery of health care and is willing to explore new methods consistent with ethical standards."

3. That the following principles and guidelines be endorsed with respect to the development of Health Maintenance Organizations in the State of Florida:

 1. The primary concern of the Florida Medical Association in the matter of HMO's is protection of the patient.

 2. Promoters of the HMO concept should keep in mind that this system of health care delivery remains unproven in many areas. Only about 3% of the nation's population presently receives health services through such a system. The Kaiser Plan, often cited as an HMO model, is not an adequate illustration of the concept because its enrollment consists largely of healthy individuals and a minority of high risk groups.

 3. The Florida Medical Association is not opposed to new concepts in health care delivery but would be opposed if these concepts are proposed as a uniform replacement for existing forms of care.

 4. If Florida law prevents the development of experimental approaches to health care delivery, permissive legislation should be enacted. If such barriers to the development of new health systems are removed, regulatory legislation should be developed promptly for the protection of the patient.

 The Florida Medical Association does not feel that hurried legislation should be enacted in the HMO field and more study is needed, but if regulatory legislation is developed the following points should be included:

 1. The professional peer review concept should be a viable element of any HMO.

 2. Any HMO should document its financial responsibility and establish fiscal obligation for patient care.

 3. HMO's should specify limitations on the total amounts of service available to any individual.

 4. HMO by-laws should not prohibit deductible payments as a means for discouraging over-utilization.

 5. By-laws of HMO's should not interfere with the right of physicians to select the method by which they will be paid for their services.

 6. Only physicians licensed to practice medicine in the State of Florida should be permitted to render medical service through an HMO.

 The Committee recommends that the FMA support HMO regulatory legislation which clearly embodies the six principles listed above.

4. That Florida Health Care Plan, Inc., of Daytona Beach be advised of the AMA resolution on Health Maintenance Organizations which states:

 "Resolved, that the HMO concept is still experimental and unproven as a nationally applicable solution to problems on health care delivery and cost; and be it further

 "Resolved, that the American Medical Association regrets the wide governmental support given this mechanism prior to valid proof of its general effectiveness; and be it

 "Resolved, that the American Medical Association continue to study and evaluate HMO's and keep the profession advised."

 In view of this resolution and since the FMA is in the process of establishing guidelines for physician participation and for the formation of HMO's, it would be premature to appoint a FMA representative to this organization.

5. That Florida Health Care Plan, Inc., of Daytona Beach be asked to submit its by-laws to the appropriate committee of

the Volusia County Medical Society for review and recommendations as to possible FMA representation. The FMA would then consider further the request of Florida Health Care Plan, Inc., for FMA representation on its Board of Directors.

6. That groups wishing to develop a Health Maintenance Organization be encouraged to consult with the local county medical society for review and recommendations.

Board Action No. 13
Health Maintenance Organizations

Upon recommendation of the Reference Committee Board Action No. 13 was adopted.

(See Report of Board of Governors, page 59.)

Board Action No. 19
Health Maintenance Organizations

Upon recommendation of the Reference Committee Board Action No. 19 was adopted.

(See Report of Board of Governors, page 60.)

Ad Hoc Committee on Florida Medical Insurance Trust

Upon recommendation of the Reference Committee the report of the Ad Hoc Committee on Florida Medical Insurance Trust was adopted as presented.

Ad Hoc Committee on Florida Medical Insurance Trust

HENRY J. BABERS JR., *Chairman*

The Committee held two meetings during the year, on September 26 and November 12. The majority of members of the Committee were present at both meetings.

In November 1969 the Florida Medical Insurance Trust instrument had been completed and literature and information concerning the program was mailed to each physician in the state, announcing the details of the Trust Program. On December 1, 1969, a concentrated enrollment effort was made by the entire sales force of Blue Shield to assure that all eligible physicians in the state were contacted about this new plan both for themselves and their employees. The group became effective on January 1, 1970, thus providing all of the physicians in the state at this time an opportunity to enroll themselves and their employees in this program.

At the September 27 meeting the Committee was provided with information which outlined the claims experience of the group since its inception. It was the carrier's contention that with this experience a rate increase was necessary. The Committee reviewed this information and was not entirely convinced, and asked that a more detailed breakdown of the experience be provided the Committee.

The November 12 meeting was held to consider the additional experience breakdown requested in the previous meeting. After considerable deliberation and discussion, the Committee reached an agreement to continue the program with the next enrollment period for eighteen months and accepted the carrier's recommendations for the increase in the hospitalization part of the program. However, it was the determination by the Committee not to accept the step-rated life insurance program as advocated by the carrier but that in view of all factors concerned it was felt that the total membership would benefit to a



All of these women are past presidents of the Woman's Auxiliary to the Florida Medical Association. Shown here at the Auxiliary Awards Luncheon are (seated): Mrs. Abbott Y. Wilcox Jr., St. Petersburg; Mrs. C. H. Gilliland, Gainesville; Mrs. John M. Butcher, Sarasota; Mrs. Perry D. Melvin, Miami; Mrs. W. Dean Steward, Orlando; and Mrs. Willard L. Fitzgerald, Miami. Standing: Mrs. H. Quillian Jones, Fort Myers; Mrs. Gordon H. Ira, Jacksonville; Mrs. Scottie J. Wilson, Fort Lauderdale; Mrs. Arnold J. Spanjers, Winter Haven; Mrs. Edward W. Ludwig, Jacksonville, and Mrs. Russell B. Carson, Fort Lauderdale.

greater extent if we retained the composite rating structure on this part of the program.

The program was then opened in December 1971, January and February 1972.

Following is a report from the carrier concerning the program:

New Enrollment from 12/1/71 to 3/1/72

Blue Cross-Divisions	Blue Shield Subs.	Life Subs.	Total Volume
333	711	484	$ 8,257,500
All Enrollments in Group to Date:			
2,045	5,865	4,960	$88,810,501

The recommendations and motions of the Committee have been forwarded to the Board of Governors and are not included in this report at this time.

Resolution 72-4
Blue Cross-Blue Shield
Lee-Hendry County Medical Society

The Reference Committee recommended that Resolution 72-4, regarding Florida Blue Cross-Blue Shield, not be adopted as the information is available and the problem seems to be one of communication.

Resolution 72-4 was not adopted.

Referrals by 1971 House of Delegates

Resolution 71-24
Medicare Program Benefits

The Reference Committee concurred with the recommendation of the Board of Governors that Resolution 71-24 be adopted.

The recommendation was carried that Resolution 71-24 be adopted.

(See Report of Board of Governors, page 58.)

Resolution 71-24

Medicare Program Benefits

Whereas, Under Medicare Part B of the Social Security Act, Insurance Companies, Corporations and Individuals who have incurred medical bill responsibility as a result of liability can have these paid by Medicare, and

Whereas, This Medicare program should be utilized for those eligible for its benefits and not for relief of defendant Carriers, Corporations or Individuals, and

Whereas, People provided for under various Workmen's Compensation Laws are not eligible for Medicare benefits, therefore be it

RESOLVED, That the Florida Medical Association go on record favoring immediate plugging this inequitous loophole in the Medicare law which permits such as mentioned from escaping their due responsibility when liable, and be it further

RESOLVED, That the Senators and Congressmen from the State of Florida be promptly informed of the sense of this resolution so that legislative action may be initiated for preventing this drain on the Medicare program.

Resolution 71-25
Medicare: Ostomy Irrigation Equipment

The Reference Committee concurred with the Board of Governors recommendation that Resolution 71-25 not be adopted,

Motion carried, and Resolution 71-25 was not adopted.

(See Report of Board of Governors, page 58.)

Board Action No. 3
Members Insurance

Upon recommendation of the Reference Committee Board Action No. 3 concerning Members Insurance was adopted.

(See Report of Board of Governors, page 58.)

Board Action No. 4
Peer Review

Upon recommendation of the Reference Committee Board Action No. 4 concerning peer review policy was adopted.

(See Report of Board of Governors, page 58.)

Board Action No. 6
Peer Review Contract

The Reference Committee recommended that Board Action No. 6, concerning Peer Review Contract, be amended by inserting the word "adequate" to follow the word "provide," and that it be adopted as amended.

It was adopted as amended.

(See Report of Board of Governors, page 58.)

Board Action No. 21
Professional Liability Insurance

Upon recommendation of the Reference Committee Board Action No. 21, concerning Professional Liability Insurance was adopted.

(See Report of Board of Governors, page 60.)

Board Action No. 25
Committee on Advisory to Blue Shield and Fiscal Intermediaries

Upon recommendation of the Reference Committee, Board Action No. 25 was adopted.

(See Report of Board of Governors, page 61.)

Board Action No. 27
1971 Relative Value Studies

Upon recommendation of the Reference Committee, Board Action No. 27 concerning the 1971 RVS was adopted.

(See Report of Board of Governors, page 61.)

Resolution 72-36
Five-Digit Coding—Blue Cross-Blue Shield
Palm Beach County Medical Society

The Reference Committee recommended that Resolution 72-36 not be adopted as this practice

is in the process of being implemented by a directive of the Board of Blue Shield.

There was discussion.

Resolution 72-36 was not adopted. (Vote 97:43)

Board Action No. 37
Resolution 72-1, Health Insurance Coverage for Newborn Infants

The Reference Committee recommended that Board Action No. 37 recommending disapproval of Resolution 72-1 not be adopted.

There was discussion.

Board Action No. 37 was not adopted.

(See Report of Board of Governors, page 62.)

Resolution 72-1
Health Insurance Coverage for Newborn Infants
Lee-Hendry County Medical Society
Sarasota County Medical Society

The Reference Committee recommended that Resolution 71-2 be amended by inserting a period after the word "infants" in the first "Resolved" and deleting the remainder of the resolution.

The amendment was adopted.

The Reference Committee recommended that Resolution 71-2 be adopted as amended.

It was adopted.

Resolution 72-1

Health Insurance Coverage for Newborn Infants

RESOLVED, That the Florida Medical Association urges the Legislature of the State of Florida to enact enabling legislation to require health insurance companies licensed in this state to make every effort to inform policy holders regarding coverage for newborn infants.

Board Action No. 40
Interns and Residents—Blue Shield

Upon recommendation of the Reference Committee Board Action No. 40 concerning Interns and Residents and Blue Shield was adopted.

(See Report of Board of Governors, page 62.)

Board Action No. 45
FIRP Committee

Upon recommendation of the Reference Committee Board Action No. 45 concerning dissolution of the FIRP Committee was adopted.

(See Report of Board of Governors, page 62.)

Board Action No. 49
FMA Investment Plan

Upon recommendation of the Reference Committee Board Action No. 49, concerning the FMA Investment Plan was adopted.

(See Report of Board of Governors, page 62.)

Resolution 72-5
Suspension of Payments
Pinellas County Medical Society

Upon recommendation of the Reference Committee Resolution 72-5, Suspension of Payments, was adopted.

Resolution 72-5

Suspension of Payments

RESOLVED, That suspended payments for assigned cases be reinstituted and that no payments be suspended until all such cases have been reviewed by the State Peer Review Committee, including a hearing of the physician by that committee.

Resolution 72-6
Medicare Directives
Pinellas County Medical Society

The Reference Committee recommended that Resolution 72-6, Medicare Directives, be amended by adding the words "and to all hospitals" following the word "physicians", and that the resolution be adopted as amended.

There was discussion.

Resolution 72-6 was adopted as amended.

Resolution 72-6

Medicare Directives

RESOLVED, That all directives be published 30 days before going into effect and circularized to all physicians and to all hospitals with an envelope stamped in red "Medicare Directive."

Resolution 72-7
Time Limit for Peer Review
Pinellas County Medical Society

Upon recommendation of the Reference Committee Resolution 72-7, Time Limit for Peer Review, was adopted.

Resolution 72-7

Time Limit for Peer Review

RESOLVED, That a letter initiating the following action shall be addressed to the physician involved, with copies to the Florida Medical Foundation, State Peer Review Committee and the local Peer Review Committee and other committees involved: All cases submitted for Peer Review must be reviewed by the local Peer Review Committee within 60 days of being received. If the time is longer than sixty days, a written statement be submitted by the local Peer Review Committee stating the reasons for this delay. That the State Peer Review Committee review all cases by the local Peer Review Committee within a sixty day period. If there is a delay, a statement must be submitted to the physician involved as to the reason for the delay.







The Journal's photographer attended the Presidential Reception during the Annual Meeting and collected the pictures which appear on this page and the page opposite: Upper left—Dr. and Mrs. Burns A. Dobbins Jr., Fort Lauderdale. Upper center—Dr. and Mrs. Floyd K. Hurt, Jacksonville (center), Mr. and Mrs. Frank Mitchell, Chesapeake, Va. (left) and Mr. and Mrs. Hew Wynne, Mobile, Ala. Mrs. Mitchell and Mrs. Wynne are daughters of the Hurts. Upper right—Dr. and Mrs. William J. Dean, St. Petersburg. Lower left—Dr. and Mrs. W. Dean Steward, Orlando. Lower center—Mrs. G. Prentiss Lee, Portland, Ore., President of the Woman's Auxiliary to AMA; Mrs. Floyd K. Hurt, Jacksonville; and Mrs. William J. Dean, St. Petersburg. Lower right: Dr. Samuel M. Day, Jacksonville (in disguise); Mr. J. Dan Lewis, Jacksonville; and Mrs. Day.



Upper left—Dr. and Mrs. Eugene G. Peek Jr., Ocala. Upper center—Dr. and Mrs. Floyd K. Hurt, Jacksonville (left); and Dr. and Mrs. William J. Dean, St. Petersburg. Upper right—Dr. and Mrs. W. Hugh Mathews, Jacksonville. Lower left—Mrs. John Monahan, Orlando; Mrs. W. Harold Parham, Jacksonville; and Mrs. John Mitchell Jr., Jacksonville. Lower center—Dr. Jere W. Annis, Lakeland; Dr. and Mrs. Vincent P. Corso, Miami; Mrs. Annis; Dr. and Mrs. Jack Q. Cleveland, Coral Gables. Lower right—Dr. William C. Roberts, Panama City.

Resolution 72-8
Specialty Representation—State Peer Review Committee
Pinellas County Medical Society

The Reference Committee recommended that Resolution 72-8 not be adopted as the chairman of the Committee on Peer Medical Utilization Review stated that these principles are a part of committee procedure.

Resolution 72-8 was not adopted.

Resolution 72-9
Information Required for Peer Review
Pinellas County Medical Society

The Reference Committee recommended that Resolution 72-9 be amended by deleting the first and third "Resolved" sections.

It was adopted.

Resolution 72-9 was adopted as amended.

Resolution 72-9

Information Required for Peer Review

RESOLVED, That action of the State Peer Review Committee requiring a personal appearance of a physician should require him to bring only such information as will answer the specific questions regarding the previous action of the committee, therefore, be it further,

RESOLVED, That action by the State Peer Review Committee with reasons stated, be sent in writing to the physician in question with a copy to the local Peer Review Committee.

Resolution 72-10
Peer Review—FMA Relative Value Studies
Pinellas County Medical Society

The Reference Committee recommended that Resolution 72-10 concerning guidelines for Peer Review and the FMA RVS, not be adopted as the individual profile is usually the basis of decision.

Resolution 72-10 was not adopted.

Resolution 72-17
Blue Shield Contract Coverage
Pinellas County Medical Society

The Reference Committee recommended that Resolution 72-17, concerning Blue Shield Contract Coverage, not be adopted as Blue Shield must compete with the private carrier in its selling effort.

A motion was made that the Reference Committee's recommendation not be accepted and that Resolution 72-17 be adopted.

Resolution 72-17 was adopted.

Resolution 72-17

Blue Shield Contract Coverage

RESOLVED, That it be recommended to the Blue Shield Board of Florida and the Florida Medical Association, Committee of 17, that all contracts providing essentially less than 50 per cent prepaid coverage be phased out and that all new contracts provide the usual, customary and reasonable coverage *or* coverage that will provide at least 60 per cent of usual, customary and reasonable fees.

Resolution 72-19
1971 Relative Value Studies—Blue Shield
Pinellas County Medical Society

The Reference Committee recommended that Resolution 72-19 not be adopted as this procedure was already in practice.

A motion was made that the Reference Committee's recommendation not be accepted and that Resolution 72-19 be adopted.

Resolution 72-19 was adopted.

Resolution 72-19

1971 Relative Value Studies—Blue Shield

RESOLVED, that it be recommended to the Florida Blue Shield Board and the Florida Medical Association, Committee of 17, that all usual, customary and reasonable contracts of Blue Shield of Florida, use as one of their criteria, the 1971 Relative Value Study of the Florida Medical Association.

Resolution 72-21
Support of Blue Shield
Hillsborough County Medical Association

The Reference Committee recommended that Resolution 72-21, Support of Blue Shield, be adopted.

It was adopted.

Resolution 72-21

Support of Blue Shield

RESOLVED, That the Hillsborough County Medical Association recommends to the Florida Medical Association that Blue Shield of Florida, Inc. be assured of the support of its participating physicians, and that county medical societies and individual physicians actively support the strengthening and maintaining of Blue Shield in its programs.

Resolution 72-22
Statewide Health Data System
Hillsborough County Medical Association

Resolution 72-24
Statewide Health Data System
Duval County Medical Society

The Reference Committee considered Resolutions 72-22 and 72-24 and recommended that

Resolution 72-24 be amended by adding after the word "foundations" the words "after legal consultation."

The amendment was adopted.

The Reference Committee recommended that the amended Resolution 72-24 be substituted for Resolutions 72-22 and 72-24, to be called Substitute Resolution 72-24, Statewide Health Data System.

Substitute Resolution 72-24 was adopted.

Substitute Resolution 72-24

Statewide Health Data System

RESOLVED, That, in order to improve the quality of medical care, to more effectively control the cost of such care, to promote the educational aspects of Peer Review, and thereby to substantially improve the physician's image and help preserve our present system of medical care, a Statewide Health Data System be endorsed, aided and supported by the Florida Medical Association and the Florida Medical Foundation and the component county societies and local foundations, after legal consultation.

Resolution 72-30
JCAH Bulletin #62
Dade County Medical Association

Upon recommendation of the Reference Committee Resolution 72-30 concerning the JCAH Bulletin #62 was adopted as presented.

Resolution 72-30

JCAH Bulletin #62

RESOLVED, That the Florida Medical Association urge the AMA (which is a component part of the Joint Commission on Accreditation) to request the Joint Commission on Accreditation to withdraw Bulletin #62.

Resolution 72-32
Medicare—Explanation of Medical Benefits
Dade County Medical Association

The Reference Committee recommended that Resolution 72-32 be amended by deleting "E.O.M.B." and adding the words "summary report," and that it be adopted as amended.

There was discussion.

Resolution 72-32 was adopted as amended.

Resolution 72-32

Medicare—Explanation of Medical Benefits

RESOLVED, That the Florida Medical Association request Blue Shield of Florida to make available to non-assignment physicians, when duly authorized in writing by the beneficiary, a copy of the summary report.

Resolution 72-33
Medicare—Specialist Definition
Dade County Medical Association

The Reference Committee recommended that Resolution 72-33 concerning definition specialist with regard to Medicare, not be adopted. The Chairman of the Reference Committee advised that a Minority Report would be presented by one of its members, Dr. Charles F. Tate Jr.

Minority Report
Resolution 72-33
Medicare—Specialist Definition

Dr. Tate:

"As president last year of the Dade County Society of Internal Medicine, I was asked to carry the ball regarding this subject.

"Personally, I can see no problem. I know many feel very strongly otherwise.

"But the problem has to be faced and the sooner we do the better. It is an accomplished fact in other states.

"In just the past two weeks very strong requests have again been received by Blue Shield to set up specialty listings.

"For many of you who may feel the five-digit coding system will do the job—it won't—it is unacceptable for Medicare purposes.

"I strongly urge the House to face its responsibility and handle this problem by passing this resolution."

There was discussion, and upon a voice vote, Resolution 72-33 was not adopted.

Resolution 72-34
Self-Insurance Program for Professional Liability Insurance
Dade County Medical Association

Upon recommendation of the Reference Committee Resolution 72-34 concerning Self Insurance Program for Professional Liability Insurance was not adopted.

Resolution 72-35
Standard Attending Physician's Form
Palm Beach County Medical Society

Upon recommendation of the Reference Committee Resolution 72-35 was adopted as presented.

Resolution 72-35

Standard Attending Physician's Form

RESOLVED, By the FMA that it urge Florida Blue Cross-Blue Shield to consider redesigning their Attending Physician's Reports form to fit as closely as possible the general format of the standard form as designed by the AMA and the Health Insurance Council.

Dr. Moseley: "Mr. Speaker, I wish at this time to express my gratitude to the members of the



Congressman Wilbur Mills (center), Chairman of the House Ways and Means Committee, was the featured speaker for the FLAMPAC-Auxiliary Luncheon during the FMA Annual Meeting. He was introduced by FLAMPAC President Joseph C. Von Thron, M.D., Cocoa Beach (right). At left is FMA President Floyd K. Hurt, M.D., Jacksonville.

Committee, Drs. Robert L. Andreae, Robert F. Dickey, James M. Stem and Charles F. Tate Jr., and to our secretary, Mrs. Mary Tai White. Mr. Speaker, this concludes the report of Reference Committee No. V."

A motion was made that a vote of thanks be extended to Dr. Robert E. Zellner for outstanding work done on behalf of the Association. Dr. Zellner was recognized with applause.

Preceding the election of FMA officers Dr. Hurt, President, assumed the Chair and outlined what the qualifications of the President-Elect of the FMA should be:

"He should be wise, smart, energetic, a persuader and a fluent speaker. He must be a social mixer and able to communicate to all sorts of intelligent and unintelligent people. He should have a normal brain and liver scan, be in good physicial condition and run a mile in 8 minutes. He should be able to go without sleep so that he can fly with the eagles in the day time and the owls at night . . . he must have a well constructed rear end for long hours of sitting and to receive various forms of trauma . . . this modular man will make a good President."

Elections

President-Elect

The Speaker opened the floor for nominations for the office of President-Elect of the Association for 1972-1973.

Dr. John Kaminski, Brevard County, placed in nomination the name of Dr. Joseph C. Von Thron of Cocoa Beach.

Dr. Von Thron's nomination was seconded by Dr. Rufus Broadaway, Dade County; Dr. Leo Wachtel, Duval County; Dr. Ed Annis, Dade County; and Dr. John Glotfelty, Polk County.

Nominations were closed and a unanimous ballot cast for Dr. Von Thron.

Dr. Von Thron was asked to come forward and take his place at the Speaker's table.

Dr. Von Thron: "I am honored and pleased and will do my utmost to serve to the best of my ability. I am not sure I have the qualifications Dr. Hurt mentioned but I will do my best. Thank you very much."



Having just been chosen as FMA's President Elect, Joseph C. Von Thron, M.D., Cocoa Beach, conveys his thanks to the House of Delegates.

Vice President

The floor was opened for nominations for the office of Vice President.

Dr. Richard Hodes, Hillsborough County, nominated Dr. John C. Fletcher of Tampa. The nomination was seconded by Dr. James Richards Jr., Orange County; Dr. Bob Webster, Leon-Wakulla-Jefferson Counties; Dr. David Overbey, Pinellas County; Dr. Richard Clay, Dade County; and Dr. Harry Reinstine, Duval County.

Dr. Robert J. Brennan, Broward County, placed in nomination the name of Dr. Ray E. Murphy Jr., of Pompano Beach.

Dr. Murphy's nomination was seconded by Dr. Clyde Collins, Duval County; Dr. Richard Fleming, Dade County; and Dr. John Blackburn, Brevard County.

Nominations were closed, and the vote was by secret ballot with the Credentials Committee serving as tellers for the House.

The Speaker announced that Dr. Fletcher had been elected Vice President.

Speaker of the House

The floor was opened for nominations for the office of Speaker of the House.

Dr. Vincent Corso, Dade County, placed in nomination the name of Dr. Franklin J. Evans, Coral Gables. The nomination was seconded by Dr. Leonard Masters, Duval County; Dr. Sam Kaplan, Sarasota County; Dr. Bernard Kimmel, Palm Beach County; Dr. Donald Nikolaus, Pinellas County; Dr. Charles Tate, Dade County; and Dr. Byron Thames, Orange County.

Nominations were closed and a unanimous ballot cast for Dr. Evans.

Dr. Evans: "I have always been envious of the officers introducing their better half and would like to introduce my wife, Jean, and my daughter, Holly, and stepmother."

Vice Speaker

Nominations for the office of Vice Speaker were called for.

Dr. Edward Stoner, Orange County, nominated Dr. Louis C. Murray of Orlando.

Dr. Murray's nomination was seconded by Dr. Charles Kahn, Escambia County; Dr. Victor Knight Jr., Hillsborough County; Dr. William Straight, Dade County; and Dr. Walter Winchester, Pinellas County.

Nominations were closed and a unanimous ballot cast for Dr. Murray.

Secretary and Treasurer

The Speaker called for nominations for the offices of Secretary and Treasurer.

Dr. Harlan Johnston, Duval County, nominated Dr. James W. Walker of Jacksonville. The nomination was seconded by Dr. James Stem, Pinellas County; and Dr. Calvin Martin, DeSoto-Hardee-Glades Counties.

Nominations were closed and a unanimous ballot cast for Dr. Walker.

AMA Delegates

The Vice Speaker assumed the Chair and called for nominations for election of AMA Delegates and Alternates for two year terms beginning January 1, 1973, and expiring December 31, 1974.

The first vacancy for AMA Delegate was for the expiring term of Dr. Francis T. Holland who held Seat No. 3. Dr. Nelson Kraeft, Leon-Wakulla-Jefferson Counties, nominated Dr. Holland for re-election to this position. The nomination was seconded by Dr. William Wilhoit, Escambia County; and Dr. Fred Butler, Collier County. Nominations were closed, and Dr. Holland was unanimously elected.

The Speaker called for nominations for Alternate to Dr. Holland. Dr. William Trice Jr., Hillsborough County, placed in nomination Dr. Francis C. Coleman for re-election to this position. Dr. Coleman's nomination was seconded by Dr. Sanford Mullen, Duval County; and Dr. Henry Hardin Jr., Dade County. Nominations were closed and Dr. Coleman was unanimously re-elected.

The second AMA Delegate vacancy was for the expiring term of Dr. Samuel M. Day who held Seat No. 2. Dr. Clyde Collins, Duval County, nominated Dr. Day for re-election to this position. The nomination was seconded by Dr. James Clower, Volusia County; and Dr. Henry Harrell, Marion County. Nominations were closed and Dr. Day was unanimously re-elected.

The Speaker called for nominations for alternate to Dr. Day. Dr. Richard Dever, Dade County, nominated Dr. Jack Cleveland for re-election to this position. Dr. Cleveland's nomination was seconded by Dr. Emmet Ferguson Jr., Duval County; Dr. Vernon B. Astler, Palm Beach County; and Dr. William Wilhoit, Escambia County. Nominations were closed and Dr. Cleveland was unanimously re-elected.

The third AMA Delegate vacancy was for Seat No. 5 which was currently held by Dr. Rich-

ard G. Connar. Dr. Thomas McKell re-nominated Dr. Connar for this position. The nomination was seconded by Dr. Robert Dickey, Dade County; Dr. Harry Reinstine Jr., Duval County; Dr. William Wilhoit, Escambia County; Dr. William Ruffin Jr., Alachua County; and Dr. David Hubbell, Pinellas County. Nominations were closed and Dr. Connar was unanimously re-elected.

The position of Alternate to Dr. Connar was open as Dr. Connar had moved up from this seat to Delegate upon Dr. Jere Annis' resignation. The Vice Speaker advised that the Alternate elected to this would hold this position the remainder of this term through the two year term ending December 31, 1974. He called for nominations to fill this vacancy. Dr. Richard Moore, Palm Beach County, placed in nomination the name of Dr. Bernard Kimmel for this position. The nomination was seconded by Dr. Leon Eisenman, Dade County; and Dr. F. C. Andrews, Lake County.

Dr. Francis C. Coleman, Pinellas County, nominated Dr. Charles K. Donegan as Alternate to Dr. Connar. The nomination was seconded by Dr. Emmet Ferguson Jr., Duval County; Dr. Charles Kahn, Escambia County; Dr. Irving Essrig, Hillsborough County; Dr. Franklin Norris, Orange County; Dr. William Straight, Dade County; and Dr. Robert Andreae, Broward County.

Nominations were closed, and by secret ballot, Dr. Donegan was elected as alternate AMA Delegate to Dr. Connar.

Judicial Council

The Speaker referred the House to the report of the Board of Governors, in which it nominated Dr. Nelson Zivitz, Miami Beach, for re-election to the Judicial Council for a five-year term to expire in 1977.

Motion carried that Dr. Zivitz be re-elected to membership on the Judicial Council.

Committee on Membership and Discipline

The Speaker referred the House to the Nominations for election to the Committee on Membership and Discipline as submitted by the Board of Governors in its report, and asked for additional nominations from the floor.

There were no additional nominations; the nominees submitted by the Board of Governors were unanimously elected to the Committee on Membership and Discipline (See report of Board of Governors, page 57).

Installation of Officers

Dr. Hurt introduced his daughter and her husband who were present from Mobile, Alabama, Caroline and Hew Wynne.

Dr. Hurt presented the President's Gavel and Certificate to Dr. Dean, incoming President.

Dr. Dean presented Dr. Hurt with the Past President's pin, and asked Dr. Harlan Johnston and Dr. Wilbur Sumner to escort Mrs. Hurt to the rostrum. Dr. Dean presented Mrs. Hurt with the portrait of Dr. Hurt which had hung in the Board Room of the FMA Headquarters office during the past year.

Dr. Dean: "Veronna, now you will both have the portrait and be able to see more of your husband."



Having just accepted the gavel from retiring President Floyd K. Hurt, M.D., Jacksonville, William J. Dean, M.D., St. Petersburg (left) is now in business as President of the Florida Medical Association.



William J. Dean, M.D., St. Petersburg, newly-installed President of FMA, presents the portrait of his predecessor, Floyd K. Hurt, M.D., Jacksonville, to Mrs. Hurt.

Dr. Hurt expressed appreciation to Mr. and Mrs. Elsner of Jacksonville for their excellent job as FMA photographers.

Dr. Dean: "Thank you for the confidence and I pledge I will do my best. It is your Board that will be running this organization between now and the time of the House meeting next year, and I want you to know who these people are." Dr. Dean introduced the members of the Board individually and asked that they stand.

Dr. Dean introduced his wife, Polly.

Dr. Dean announced the Board's meeting immediately upon adjournment of the House.

Dr. Donegan, Speaker of the House, introduced his wife, Barbara, and asked that Dr. Henry J. Babers Jr. lead the House in its benediction. The House of Delegates at the request of President Dean went into Executive Session at 1:00 p.m. to consider a confidential recommendation of the Board of Governors which was then presented by Dr. James Walker, discussed and approved.

The 1972 House of Delegates adjourned at 1:10 p.m.

Corrective
Important Notice
Medical & Surgical Fee Schedule
Workmen's Compensation

July 20, 1972, is the operative date of the increase in the schedule, rather than June 16, 1972.

Fees should be charged at the *old* and existing rate until rendered for services rendered July 20, 1972, and thereafter.

The delay was due to the unfortunate impossibility for the rule changes to be published in the Administrative Register until early June.

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Caution: During treatment it is recommended that the patient refrain from sexual intercourse or the husband wear a condom to avoid re-infection.
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References: **1.** Olsen, J.R.: Journal-Lancet *85*:287 (July) 1965. **2.** Giorlando, S.W.: Ob/Gyn Dig. *13*:32 (Sept.) 1971. **3.** Decker, A.: Case Reports on File, Medical Department Julius Schmid. **4.** Giorlando, S.W., Torres, J.F., and Muscillo, G.: Am. J. Obst. & Gynec. *90*: 370 (Oct. 1) 1964. **5.** Lechevalier, H.: Antibiotics Annual 1959-1960. New York, Antibiotica Inc., 1960. pp. 614-618. **6.** Friedel, H.J.: Maryland M.J., *15*:36 (Feb.) 1966.

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Editorials

Analgesics

The recently published article in the New England Journal of Medicine (286:813, 1972), was a well-designed study which compared single analgesics in patients with chronic pain. The study was done in a double-blind fashion, and three parameters of pain relief were measured. In all three parameters, propoxyphene hydrochloride* was significantly inferior to aspirin and was no different from placebo. In one method of analysis, propoxyphene and codeine were in the same group and there have been numerous other studies that have pointed out that codeine also is less effective than 650 mg. of aspirin. (See Eddy, Friebel, Hahn and Halbach in "Codeine and Its Alternatives for Pain and Cough Relief," World Health Organization, Geneva, 1970). The precise mechanism of action of analgesia for either aspirin or propoxyphene is not known, and although aspirin has a number of peripheral effects, the terms "peripherally acting substances like aspirin," and "centrally acting substances like Darvon," are loose statements which are not backed by fact. An important paper was that by Miller et al, in the JAMA 213:996, 1970, where all studies involving propoxyphene were reviewed. Several varieties of pain were included: mixed chronic pain, postpartum pain, postoperative pain, headache and periodontal pain. In no study was propoxyphene superior to aspirin and codeine in terms of analgesic effect. Other than unsubstantiated comments, there are no good data supporting the statement that propoxyphene and aspirin together have a greater effect than aspirin alone.

Just because propoxyphene has been a very popular sales item does not prove that it is particularly effective. Many of us who use analgesics in treatment of patients with chronic pain, such as cancer pain, have been singularly unimpressed with the effectiveness of propoxyphene over the years and have had the feeling that the effectiveness of propoxyphene compound is not any greater than APC tablets alone.

It all boils down to how effectiveness of a drug should be measured. In something as difficult to measure as pain relief, it is particularly important to attempt to use scientific studies to compare effectiveness. Valid studies should be of a double-blind nature and should have correct statistical analysis and design. It should be strongly pointed out that the recent New England Journal article is not the first and only one suggesting that propoxyphene is of no great value as an analgesic drug. As mentioned above, twenty double-blind studies showed no greater effectiveness than aspirin, and there are eight studies in the literature which show that propoxyphene was not superior to placebo. The matter of cost should also be emphasized, in that a dose of propoxyphene supposedly effective (65 mg.) is approximately ten times as expensive as 650 mg. of aspirin.

As there is significant abuse potential of propoxyphene it appears that the therapeutic value does not justify its extensive use. It is suggested that for the control of pain the first agent used should be aspirin in the dose of 600-900 mg. (10-15 gr.) p.o. every four hours.

S. Walter Oppelt, M. D.
Professor of Pharmacology
and Medicine
University of Florida
College of Medicine
Gainesville

*Darvon

The Business of the Practice of Medicine

An economist writing in a recent medical journal says that manifestations are evident that physicians are moving into a brand new era in their economic lives. Two recent phenomena have been the wage price freeze and the general guidelines suggested for Phase II of these controls. As medicine has always been considered a profession first and a business second, physicians, not having had the competitive and capital elements inherent in other professions, have not been confronted with the economic considerations that affected virtually every other kind of business enterprise. Physicians enter into a practice with virtual certainty of economic success, having seldom looked toward factors of good management or fiscal planning.

On the contrary, business men, forced to consider the possibility of failure in any given enterprise, must seriously consider how to finance the capital in their venture and judge whether the income and profit would be appropriate in terms of capital invested. This situation as to the practice of medicine is about to change, so the writer continues. Further he warns, it is becoming increasingly evident that all medical related costs are of such magnitude and have such impact on the consumer public that some form of control is certain for the indefinite future.

Another major factor that will probably change the attitude of the physicians toward their fiscal environment is the gravitation toward large collective practices such as foundations, HMO's, prepaid group practice or fee-for-service groups. With new concepts of capital investment, financing and use of advisor-specialists; physicians, for the first time, will be confronted with factors involved in sophisticated cost accounting, actuarial projections, capital-profit relationships and other elements routinely provided for in commerce and industry.

In the past, such traditional concepts of management, organizational structure, accounting and fiscal planning have not been readily adaptable to the small unit medical practice. Now major accounting and consulting firms are developing health service planning divisions because of the potential fiscal impact of government intervention in the industry and the inevitable development of large collective medical enterprises.

Substantial resources in terms of manpower, money and time will be needed but funds will be available from a variety of sources. Disturbingly, one source of funding will be advisors whose interests are adverse to private medical practice (government grants, fees from insurance companies, private foundations) or, to put it another way, most of the health service development funds will be provided to organizations that do not have the best interest of the physician in mind.

It may be many years before the complete limitation of fee-for-service and freedom of choice medicine is seen but it seems apparent that there will be some form of pleuralistic system. Rather than legislature to force doctors to practice in a narrow predetermined way, more likely, there will be economic pressure through subsidy of competing elements. For example, HMO's designed to conform to government thinking are receiving federal money to develop their facilities. To resist the government pattern of large prepaid group practice, doctors are forming groups of their own to organize on their own terms, independent, fee-for-service, freedom of choice medicine. The advent of fairly rigid fee controls is another significant factor that will drive individual practitioners into group practice. As long as fee levels were virtually open-ended in a noncompetitive environment, individual physicians could easily sustain a high threshold of income without being concerned excessively about the relative efficiency of business operation. Reasoning that a large group of physicians will be in a stronger position to negotiate fee adjustments and obtain various types of grants or subsidies, the so-called entrepreneur may turn quickly to the presumed efficiencies of group practice. In short, the advent of government bureaucracy in medicine will probably force a bureaucratic response.

The net effect of all of these changes is that doctors are being forced into a posture that requires fiscal knowledge and awareness. No longer can the doctor be disdainful of management, economy and planning for if he joins a well run practice of any size, he will be entering a new world of balance sheets, facility expansion, financing, negotiation of governmental agencies, labor problems and other strictly nonmedical pursuits. Through hiring advisors, he may be able to insulate himself from much of this activity; nevertheless, some degree of intelligent participation will be required.

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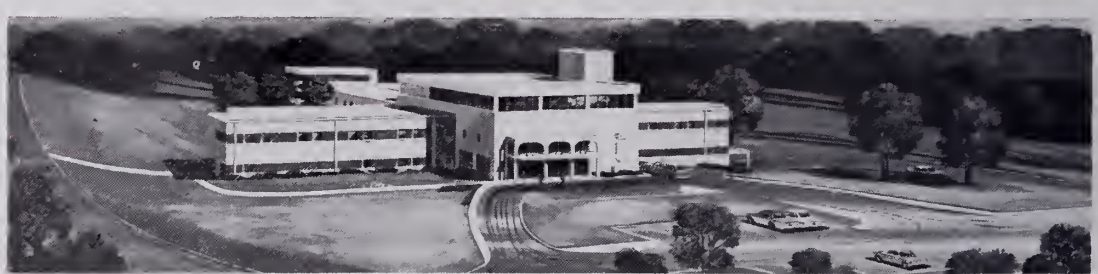
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MEETINGS

Approved by FMA Committee on Continuing Education

SEPTEMBER

4- 9 Course of Instruction in Coronary Care for the Practicing Physician, Jackson Memorial Hospital, Miami. For information: Louis Lemberg, M.D., U. of Miami School of Medicine, Box 875, Biscayne Annex, Miami 33152.

21-24 Emergency Medical Systems—National Symposiums, by University of Florida College of Medicine, Contemporary Hotel, Disneyland at Orlando. For information: Lamar Crevasse, M.D., Box 758 J. Hillis-Miller Health Center, Gainesville 32601.

OCTOBER

16-21 Course of Instruction in Coronary Care for the Practicing Physician, Jackson Memorial Hospital, Miami. For information: Louis Lemberg, M.D., U. of Miami School of Medicine, Box 875, Biscayne Annex, Miami 33152.

DECEMBER

8-10 "The Spinal Cord Injured Patient," from the Department of Orthopaedics and Rehabilitation, University of Miami School of Medicine, Americana Hotel, Miami Beach. For information: Augusto Sarmiento, M.D., Box 875, Biscayne Annex, Miami 33152.

11-13 "The Advance in Orthotics—1972," from the Department of Orthopaedics and Rehabilitation, University of Miami School of Medicine, Americana Hotel, Miami Beach. For information: Augusto Sarmiento, M.D., Box 875, Biscayne Annex, Miami 33152.

13-15 Twelfth Biennial Cardiovascular Seminar, Doral Beach Hotel, Miami Beach. For information: Marvin L. Meitus, M.D., 5080 Biscayne Blvd., Miami 33137.

11-16 Course of Instruction in Coronary Care for the Practicing Physician, Jackson Memorial Hospital, Miami. For information: Louis Lemberg, M.D., U. of Miami School of Medicine, Box 875, Biscayne Annex, Miami 33152.

National and Regional Meetings Held in Florida

NOVEMBER

2- 4 International Conference on Trichinellosis, Sheraton-Four Ambassadors Hotel, Miami. Sec.: W. C. Campbell, Ph.D., Merck Institute, Rahway, N. J. 07065.

2- 6 Association of American Medical Colleges, Fontainebleau Hotel, Miami Beach. Pres.: John A. D. Cooper, M.D., 1 Dupont Circle, Washington, D. C. 20036.

6-10 American Society of Tropical Medicine and Hygiene, Deauville Hotel, Miami Beach. Sec.-Treas.: George R. Healy, Ph.D., P.O. Box 15208, Emory University Branch, Atlanta, Ga. 30333.

19-22 Pan American Medical Association, Deauville Hotel, Miami Beach. Dir. Gen.: Joseph J. Eller, M.D., 745 5th Avenue, New York 10022.

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Scheffel H. Wright, M.D.

By way of introduction, it has been stated that "the most sensitive nerve in the human body is the one that leads to the pocketbook." From 1966 to 1972, Blue Shield, as administrator of Medicare Part B, has paid $515,474,690 to physicians in Florida. As a member of the Blue Shield Board for five years and the FMA for 40 years, I have observed this quotation to be true. We of the Board must remember that we are handling public money, therefore, public relations as well as professional relations are important.

I have often thought of the relationship between Blue Shield and the physicians of Florida as a "marriage," a voluntary union for mutual benefit to the sick. This aphorism is true as long as communication and understanding are maintained. It is for this purpose that this article is written.

I will attempt to develop this theme under two phases: first, Public Relations; second, Professional Relations.

The President of FMA in an article in December 1971 clearly noted that the physicians' image needs improving. Who should do this? A constantly recurrent complaint is that Blue Shield should promote the "Doctors' Image" because it is the "Doctors' Plan." It is imperative that we have a clear understanding of Blue Shield, *a private insurance company,* which incidentally administers the Medicare Part B provisions upon request of the FMA. Blue Shield cannot spend its private subscribers' premiums beyond a small percentage (½ of 1%), compatible with sound business principles, to develop new business. It does, however, in doing this also provide its subscribers with "Blue Shield Group Notes."

One recent article in the "Notes" clearly pointed out that "doctors' expenses are 35-45 per cent of income." Pamphlets are enclosed with each policy explaining what each contract provides in simple, understandable language; others contain excellent articles on "The Drug Problem," "The Alcohol Problem," and "Health Careers." Through its programs on TV, in newspapers and magazines it attempts to improve the "Doctors' Image" at all times. For this promotion in the public relations field, Blue Cross and Blue Shield have a fulltime Public Relations director, Mr. Dave Mancini, and budgets $415,000 for 1972.

Recently, upon the request of the Committee of 17 of FMA, Blue Shield mailed a "Physician's Image Questionnaire" to all physicians in Florida. The tabulation of the returns was quite interesting and is being evaluated and studied by the Committee of 17 and Blue Shield as to how, what, and who should do this badly needed job in Florida.

A dramatic movie, "The Fifty-Two Thousand Dollar Hour," was produced and shown to lay and professional groups and on TV throughout Florida explaining "The Blues," how they function, their benefits, and the public's need for hospitalization and medical care insurance.

An informational reference library pertaining to the facts of medical insurance and the Blues is being accumulated.

There is a continuing program of public information as to new benefits available to doctors, legislators, hospitals and Blue Cross and Blue Shield employees, who number some 2,200.

It is an acknowledged truism that "the best public relations is in the doctor's office," but, in my opinion, the FMA should be *primarily* responsible in this effort; Blue Shield at all times stands willing to cooperate.

In professional relations, the Chairman of the Board, Dr. Robert Zellner, this year is pushing aggressively a program under the committee chairmanship of Dr. Warren Quillian with Mr. J. Dan Lewis, Vice President, Physicians' Affairs, on many

Dr. Wright is a member of the Blue Shield Board of Directors.

fronts. Some of these programs are long existent, but often poorly utilized by physicians and their assistants. There are fulltime local representatives of Blue Shield, who are knowledgeable in the many ramifications of the multiple Blue Shield contracts as well as Medicare provisions. *It is to these local representatives to whom the physician should direct his questions initially.* If they do not know the answer in short order, they can refer the questioner to the most appropriate source. We should each make it a point to know these men personally.

A new program of "Physicians' Information Phone Service" is being tested in Hillsborough, Pinellas, Volusia, Broward and Palm Beach Counties, whereby the physician or his assistant can telephone, toll-free, the specially trained physician information operators in the Jacksonville office. These operators can, in a majority of instances, supply the information desired immediately if given sufficient specific information by the caller. If the program proves as successful as initial results indicate, it will be expanded.

Blue Shield and Blue Cross initially subsidized a health data system study among 10 hospitals in Jacksonville. This was a pilot program in utilization, but tremendous possibilities for expansion to many other facets of the health care system in data collection and accessibility seem possible. The Board at present is considering a similar study in Hillsborough. The potential seems unlimited, but we have to crawl before we run.

A recently inaugurated program aimed at better communication with FMA and its committees by subsidizing a fulltime assistant to the Committee of 17, which functions as an advisory committee of FMA to Blue Shield, was effected upon "17's" request. The Board of Blue Shield is also requesting members of "17" to attend Board meetings. Summaries of Blue Shield Board meetings are mailed to all members of the Committee of 17, officers of FMA, and each County Medical Society in an effort to keep them informed. Copies of these are available to any Florida physician upon request.

There are many unsolved and quite controversial problems extant in professional relations, such as implementation of the desires of the House of Delegates of FMA regarding use of Current Procedural Terminology and Coding according to the recently distributed FMA "Study of Relative Values."

Imprinting of descriptive literature of contracts is done, where applicable, with—THE BENEFITS PROVIDED BY THIS CONTRACT DO NOT NECESSARILY COVER THE PHYSICIAN'S ENTIRE FEE—as requested by the House of Delegates of FMA.

Other problems still exist, such as recognition of the specialist in medical practice; this has been requested by Medicare. The Blue Shield Board feels that this must be done by FMA before the government programs do it for organized medicine.

Notification of physicians who do not accept assignments under Medicare, when patients are paid directly, by forwarding a copy of the Explanation of Medical Benefits (EOMB) similar to the EOMB received by patients when assignment is accepted. This, I feel, is not insoluble despite existing dogmatic directions by HEW forbidding such provision which Blue Shield requested.

The terminology "more than allowable charge" imprinted on EOMBs, which has irritated physicians, is still under study by your Blue Shield representatives for more suitable phrasing, and, I believe, a change is imminent.

I believe a recent communication to all physicians, as to how fees under the Medicare program are calculated, by President J. W. Herbert is a manifestation of Blue Shield's desire to cooperate in physician relationships.

Recently adopted guidelines by the Blue Shield Board for guidance of its staff in its dealings with the Social Security Administration indicate that Blue Shield is acting to protect itself as a private insurance company and to prohibit any action not in the interest of the public which Blue Shield serves or the physicians it represents.

In summary, I might say that I know of no other insurance company which might be administering the Medicare program on whose Board of Directors we physicians have a majority representation. The Blue Shield organization is attempting to implement the desires of the physicians of Florida, provide the care to the sick of Florida and give them their just dues under the enacted legislation in a fair and equitable manner to all concerned, assist in improving the "Physicians' Image," and slow down the rapid encroachment of bureaucratic medicine.

I believe the whole secret of good professional and public relations is improved communication, education, and understanding of all concerned.

▶ Dr. Wright, 707 Dupont Building, Miami 33131.

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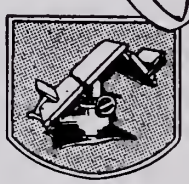
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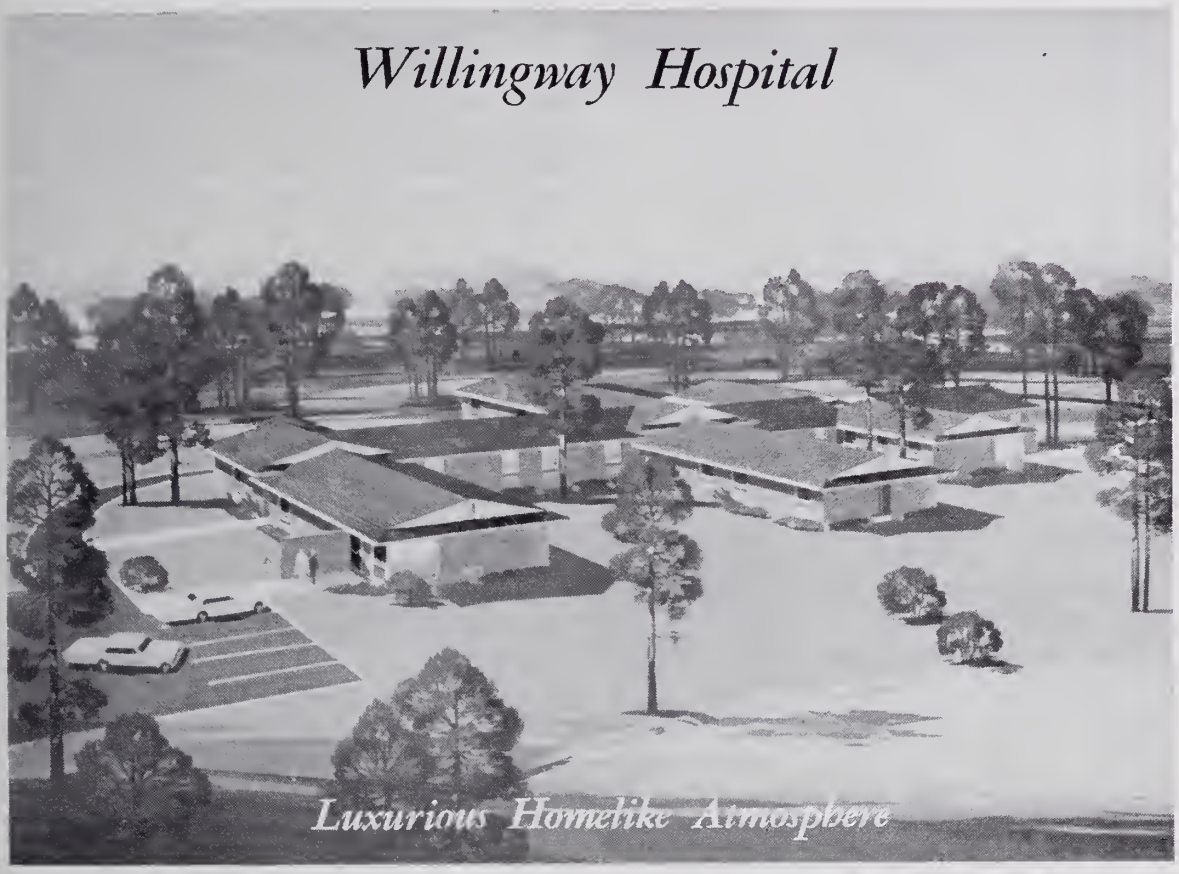
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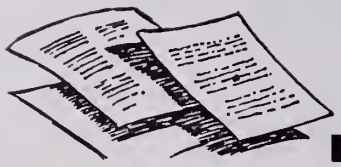
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Letters

Editor's Note: The following two letters are published with the permission of the authors and with the express intent of answering critical remarks heard around the state.

American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610

Att.: Dr. Ernest B. Howard, Executive Vice President

Re: The American Medical Association's Future

Gentlemen:

I was told recently by one of the AMA staff that membership had dropped by nearly 37,000 during 1971. Apparently there is some concern with this fact in AMA headquarters, as well as with the recent decision by at least two state societies to no longer require AMA membership for state or local membership.

I believe that the stresses on organized medicine have been increasing since World War II, and it would appear that the fabric of organized medicine is beginning to show the effects of such stress. It would be unfortunate, indeed, if the AMA could no longer effectively represent the physician and, at a time when we need to be most organized, we instead are fragmenting to an ever-increasing degree. I fear the fault lies directly with ourselves, and this includes the AMA.

For years the AMA has operated under a nonrepresentative organization where the Board of Trustees, in effect, rules with little direct responsibility to the House of Delegates and, more importantly, to the body of AMA. Membership on this all important Board is too often on the basis of you-scratch-my-back-and-I'll-scratch-yours over a period of twenty or thirty years until one is elevated to the position. As a result, the average age on the Board generally is well over sixty, and usually over seventy years. That in itself is no absolute indictment, but the judgments and responsiveness of this body have not been in keeping with the fast-moving events of the past few years and, more particularly, the demands of the average member in AMA.

I would strongly suggest that the responsibility of the delegates to the membership be strengthened immediately. This could be done through instruction and widespread plebiscite. I realize that the thought of going to the membership with important issues is so startling as to be thought downright radical. One more year like the last one, however, should convince even the most reluctant that drastic measures are necessary. In keeping with this, I also would suggest that the Board of Trustees be responsible to the House of Delegates, rather than to no one, as, in effect, they now are. I would further suggest that persons over age 60, or certainly 65, should not be in control of the policy and administrative machinery of AMA. At this time we need brilliance, decision, action, judgment, and, most of all, skilled leadership. The incumbent hierarchy and method of choosing leadership have, in part, produced the present seemingly insolvable problems. Continuation of the present situation certainly will reduce the role of AMA to complete impotence in terms of important decision-making in medical affairs of this country.

With regard to continuing education, I would suggest that AMA abandon its efforts. Under the present administration, the regional and national meetings are a joke throughout all of organized medicine. Only the most hackneyed articles are presented at these meetings, with originality of work being so rare as to be virtually nonexistent. Either drop the present continuing education program entirely, or reinfuse some vigor into present programs, and utilize virtually the only weapon left at your disposal, the *Journal of the American Medical Association*. Willy or nilly, it is still the most widely circulated scientific journal and, for this reason, is sought for certain types of articles. If you make presentation of original work at an AMA meeting a priority requirement for publishing in the Journal, then obviously the quality of your meetings will improve proportionately. Measures short of this certainly will fail as concerns the meeting.

The above may appear to be brash thoughts. Equate these thoughts with what you feel to be

the seriousness of the present situation. If, in balance, you think that a desperate situation demands desperate measures, then I would suggest that a massive infusion of democracy, going to the membership directly, and obtaining the best of leadership may just reverse the present downward trend.

I would be interested in your thoughts, if you care to share these with me. My interest, believe it or not, is the strongest possible stand organized medicine can make. Even this may not be enough at this late date.

Eugene L. Nagel, M.D.
Department of Anesthesiology
University of Miami School of Medicine
Miami, Florida 33152.

Dear Doctor Nagel:

I appreciate your long and sincere letter, and I shall try to respond to the important questions you have raised.

We have had some drop off in dues paying membership in 1971, but not the 37,000 mentioned in your letter. We lost just under 12,000 dues paying members due primarily to the loss of 8,000 members in New York State where "compulsory" AMA dues for New York State members was determined to be illegal. I believe this New York State loss reflects an unusual development which I predict will be reversed in large part during the next three to four years.

You are right that the stresses on organized medicine have been increasing since World War II, but I would submit that the stresses on most organized groups in this country have also been increasing and many national organizations, other than the AMA, are showing the strain. As the country has moved to the left with increasing centralized controls, conservative organizations have had to respond to new challenges. Having watched our organization from within the staff since 1948, it is my honest conviction that AMA has responded to the changing national climate with wisdom and a reasonable measure of flexibility. I could document this statement by referring to many specific issues and the policies that AMA has carefully enunciated with respect to them, but this letter would then become too long. I believe it is better that we chat together at our first opportunity because there is much to discuss.

I must, however, respond to certain statements you have made which I do not believe are correct or at least diverge significantly from the facts. The AMA is a representative organization with delegates selected by the 55 constituent and territorial medical associations. We now have 240 delegates and they elect the 15 members of the Board of Trustees. The President, President Elect and the Immediate Past President are ex officio voting members of the Board, and the other 12 are elected for three year terms with a maximum of three terms or 9 years. The Board, therefore, is a committee of the House of Delegates and is always responsive to it. The Board cannot develop a single policy without approval—or disapproval—by the House. Although the statement has been made frequently that the Board is not responsive to the will of the grassroots membership, I believe this impression is false. I predict that the poll that we are now conducting of the members will show a significantly high percentage of support for the existing policies of the AMA. With respect to the average age of the Board, it is now 60.7. I see nothing unusual about this age for members of a board with such responsibility and demand for complex decision-making.

Your comments about strengthening the communication between the doctors and the membership are well taken, and we are now attempting to pursue this objective via a series of actions: Polls of the membership, regional conferences, improved communications through our publications, etc.

We are now reassessing the value and effectiveness of our annual and clinical scientific meetings. We agree with you that a reassessment is in order, and I believe I can assure you that certain changes will be made during the next two years that will satisfy your demand for reappraisal.

I share your belief that AMA must take a critical look at itself and make those changes which will enhance its image and its leadership potential. I do not think I should mention some of the thinking that is now going on within the Council on Long Range Planning and Development and the Board of the AMA, but I want to assure you that forward looking and exciting thought is being given to changes which will excite you and physicians like you across the country.

Ernest B. Howard, M.D.,
Executive Vice President
American Medical Association

County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	TOTAL MEMBERS Associate	Active
Alachua	George A. Dell, Gainesville	James V. Freeman, Gainesville	2nd Tues.	80	203
**Bradford, Gilchrist, Union*					
Bay	Joseph H. Morris, Panama City	Sidney A. Daffin III, Panama City	1st Tues.	—	41
Brevard	John T. Blackburn, Melbourne	Leon H. Osmon, Melbourne	2nd Tues.	20	156
Broward	Milton P. Caster, Ft. Lauderdale	Raymond E. Parks, Ft. Lauderdale	4th Tues.	121	625
Charlotte	Roscoe S. Maxwell, Punta Gorda	Stephen R. Roddy, Punta Gorda	2nd Tues.	1	35
Clay	John M. Malone, Green Cove Springs	E. Charlton Prather, Orange Park	4th Tues.	3	18
Collier	Hoke H. Shirley Jr., Naples	Ralph E. Peterson, Naples	3rd Wed.	—	61
Columbia	J. I. Benefield, Lake City	Milton A. Lima, Lake City	3rd Wed.	2	17
Dade	Joseph H. Davis, Miami	Edward W. St. Mary, Miami	1st Tues.	387	1,748
Desoto-Hardee-Glades	Gordon H. McSwain, Arcadia	H. S. Agnew, Arcadia	1st Tues.	3	16
Duval	M. Harlan Johnston, Jacksonville	Guy T. Selander, Jacksonville	1st Tues.	74	506
Escambia	Charles J. Kahn, Penscaola	F. Norman Vickers, Pensacola	2nd Tues.	18	155
Franklin-Gulf	John W. Hendrix, Port St. Joe	W. T. Weathington, Apalachicola	Last Wed.	—	5
Highlands	Julio Sanguily, Sebring	John B. Neal, Lake Placid	3rd Mon.	3	27
Hillsborough	Irving M. Essrig, Tampa	Donald W. Irvine, Tampa	1st Tues.	80	405
Indian River	John P. Gifford, Vero Beach	James G. Punches, Vero Beach	2nd Tues.	3	40
Lake	Robert H. Hux, Leesburg	Bergon F. Brokaw, Leesburg	1st Wed.	—	50
Lee-Hendry	J. S. Hagen III, Ft. Myers	Oliver, A. Sorsdahl, Ft. Myers	3rd Mon.	13	97
Leon-Wakulla-Jefferson	E. G. Haskell Jr., Tallahassee	R. P. Johnson, Tallahassee	1st Mon.	24	113
Madison	A. F. Harrison, Madison	O. D. Benitez, Madison	1st Tues.	—	5
Manatee	Joseph H. Sloss, Bradenton	J. S. Stoutmyer, Bradenton	2nd Tues.	8	86
Marion	David C. Albritton, Ocala	Thomas D. Guin, Ocala	3rd Tues.	11	53
**Levy*					
Monroe	Ronald H. Chase, Key West	Robert E. Lazarus, Key West	1st Thurs.	1	37
Nassau	Cecil B. Brewton, Fernandina Beach	Farid Ullah, Fernandina Beach	2nd Thurs.	4	12
**Baker*					
Okaloosa	Ted D. Laughlin, Ft. Walton Beach	James E. Huddlestun, Ft. Walton Bch.	1st Wed.	1	39
Orange	Franklin G. Norris, Orlando	Marian A. Floyd, Orlando	3rd Wed.	120	427
Osceola	John O. Rao, Kissimmee	Archie E. Tate, St. Cloud	3rd. Wed.	—	8
Palm Beach	Richard B. Moore, W. Palm Beach	Dick L. VanEldik, W. Palm Beach	4th Mon.	73	383
Panhandle	Pat W. Woodward, Marianna	Richard H. Schultz, Marianna	1st Thurs.	1	30
Pasco-Hernando-Citrus	James M. Marlowe, New Port Richey	W. Randall Jenkins, Inverness	2nd Thurs.	1	38
**Sumter*					
Pinellas	Allyn B. Giffin, St. Petersburg	W. S. McKeithen, St. Petersburg	1st Mon.	112	472
Polk	Marvin G. Burdette, Lakeland	Paul I. Lopez, Lakeland	2nd Wed.	14	226
Putnam	Thelbert R. Suggs, Crescent City	Kathleen M. Santi, Palatka	2nd Tues.	2	11
St. Johns	W. W. O'Connell, St. Augustine	V. A. Lockwood, St. Augustine	3rd Tues.	—	26
**Flagler*					
St. Lucie-Okeechobee-Martin	H. H. Raulerson Jr., Okeechobee	Bernard D. Ross, Ft. Pierce	3rd Thurs.	1	56
Santa Rosa	Elbert W. Sutton, Milton	Claude J. Barnes, Milton	2nd Tues.	—	14
Sarasota	Howard E. Hartman, Sarasota	Clement H. DeMasi, Sarasota	2nd Tues.	25	165
Seminole	Gonzalo Huaman, Sanford	Jorge Gomez, Sanford	2nd Tues.	1	33
Suwannee-Hamilton-Lafayette	Alex Kish, Live Oak	F. T. Mickler, Jasper	1st Sat.	—	7
Taylor	John H. Parker Jr., Perry	John A. Dyal Jr., Perry	Last Fri.	—	7
**Dixie*					
Volusia	Harry G. Gillis, Daytona Beach	Thomas L. Wells, Daytona Beach	2nd Tues.	7	152
Walton	Lloyd L. McCormack, DeFuniak Spgs.	Thomas G. Spence, DeFuniak Spgs.	2nd Tues.	—	8
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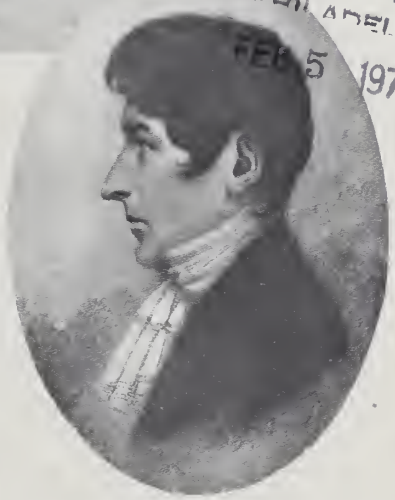
AUGUST 1972

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MEDICAL HISTORY ISSUE



Everybody experiences psychic tension.



Most people can handle this tension.



Some people develop excessive psychic tension and need your counseling,



and a few may need counseling
and the psychotropic action of Valium® (diazepam).

Before deciding to make Valium (diazepam) part of your treatment plan, check on whether or not the patient is presently taking drugs and, if so, what his response has been. Along with the medical and social history, this information can help you determine initial dosage, the possibility of side effects and the ultimate prospects of success or failure.

While Valium can be a most helpful adjunct to your counseling, it should be prescribed only as long as excessive psychic tension persists and should be discontinued when you decide it has accomplished its therapeutic task. In general, when dosage guidelines are followed, Valium is well tolerated (see Dosage). For convenience it is available in 2-mg, 5-mg and 10-mg tablets.

Drowsiness, fatigue and ataxia have been the most commonly reported side effects.

Until response is determined, patients receiving Valium should be cautioned against engaging in hazardous occupations requiring complete mental alertness, such as driving or operating machinery.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.

Valium®
(diazepam)

To help you manage excessive psychic tension

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AUGUST, 1972 • VOLUME 59 • NUMBER 8

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AUGUST COVER—A Collage of photographs from the articles in this issue depicting medical history.

President's Page



You Are Well Represented

Did you ever say, "The AMA doesn't represent me"? If you have made such a statement, you couldn't be further from the truth. As a member of the Florida Medical Association, you are definitely represented by the AMA and I might say, represented well. Your Florida delegation of six delegates and six alternates were all present at the recent San Francisco AMA Annual Meeting and the rest of the country knew that Florida was there. The Florida group is an outstanding group of old pros who have been at this, for the most part, a long time. They see that their ideas, which are our ideas, are carried out. The delegation is headed by Dr. Francis Holland of Tallahassee and the other members backing him up are: Drs. Burns Dobbins, Robert Zellner, Sam Day, Richard Connar, and Rufus Broadaway. Your alternate delegates are: Drs. Eugene Peek, Francis Coleman, James Cook, Charles Donegan, Jack Cleveland, and Byron Thames. Dr. Jere Annis was re-elected to the Board of Trustees and Dr. Burns Dobbins was appointed to the Judicial Council at this recent meeting. These men were up every morning for a 7:30 a.m. caucus and discussion of all the resolutions and business to be carried on that day in the House of Delegates. The outcome or business that is transacted by the House of Delegates is very definitely a product of each state society—brought forward and presented by its own delegation. Florida has been very effective because of these men that we have sent back year after year. They are well known by the other state delegations and command respect.

If at any time we feel that our wishes are not being heard, we should, as individuals, be sure that this is not a fact! There are several methods that can be used to present one's ideas. A man may bring this up before his own county society, have a resolution to the FMA passed and then carried on to the AMA. If the problem doesn't seem to warrant going through the usual channels, a member may contact any one of our delegates or alternates directly and express his views or ideas. I can assure you that any thoughts a man may have will receive serious consideration by our representatives. Try it!

As you can tell from this article, I am personally very much impressed by Florida's delegation to the American Medical Association and feel that they deserve a real vote of thanks and confidence from everyone of our members. Let's all try even harder to stand closely together and support these men so that they can continue to represent us in our struggle to keep medicine under the free enterprise system.

William J. Dean, M.D.

Pinworm therapy is often a family affair



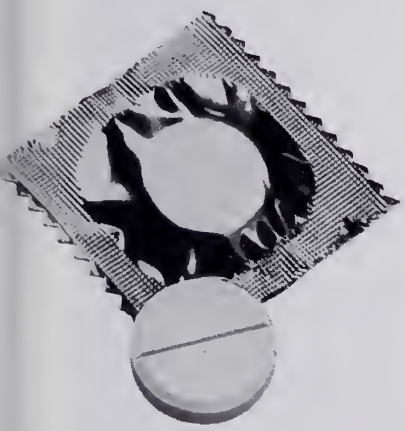


Contraindications: History of hypersensitivity to thiabendazole.
Warnings: If hypersensitivity reactions occur, drug should be discontinued immediately and not resumed. Rarely, erythema multiforme has been associated with thiabendazole therapy; in severe cases (Stevens-Johnson syndrome), fatalities have occurred. Because CNS side effects may occur quite frequently, activities requiring mental alertness should be avoided. Safe use in pregnancy or lactation has not been established.
Precautions: Ideally, supportive therapy is indicated for anemic, dehydrated, or malnourished patients prior to initiation of anthelmintic therapy. In presence of hepatic or renal dysfunction, patients should be carefully monitored.
Adverse Reactions: Most frequently encountered are anorexia, nausea, vomiting, and dizziness. Less frequently, diarrhea, epigastric distress, pruritus, weariness, drowsiness, giddiness, and headache have occurred. Rarely, tinnitus, hyperirritability, numbness, abnormal sensation in eyes, blurring of vision, xanthopsia; hypotension, collapse; enuresis; transient rise in cephalin flocculation and SGOT; perianal rash, cholestasis and parenchymal liver damage; hyperglycemia; transient leukopenia; malodor of the urine, crystalluria, hematuria; appearance of live Ascaris in the mouth and nose. Hypersensitivity reactions

A New Dosage Form:

Chewable Tablets 500 mg Mintezol®

(THIABENDAZOLE | MSD)



so easy to take everyone in the family will keep to the regimen you prescribe

include: fever, facial flush, chills, conjunctival injection, angioedema, anaphylaxis, skin rashes, erythema multiforme (including Stevens-Johnson syndrome), and lymphadenopathy.
Supplied: Chewable tablets, containing 500 mg thiabendazole, in boxes of 36, strip packaged, individually foil wrapped; Suspension, containing 500 mg thiabendazole per 5 cc, in bottles of 120 cc.

For more detailed information, consult your MSD representative or see the Direction Circular. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

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addendum

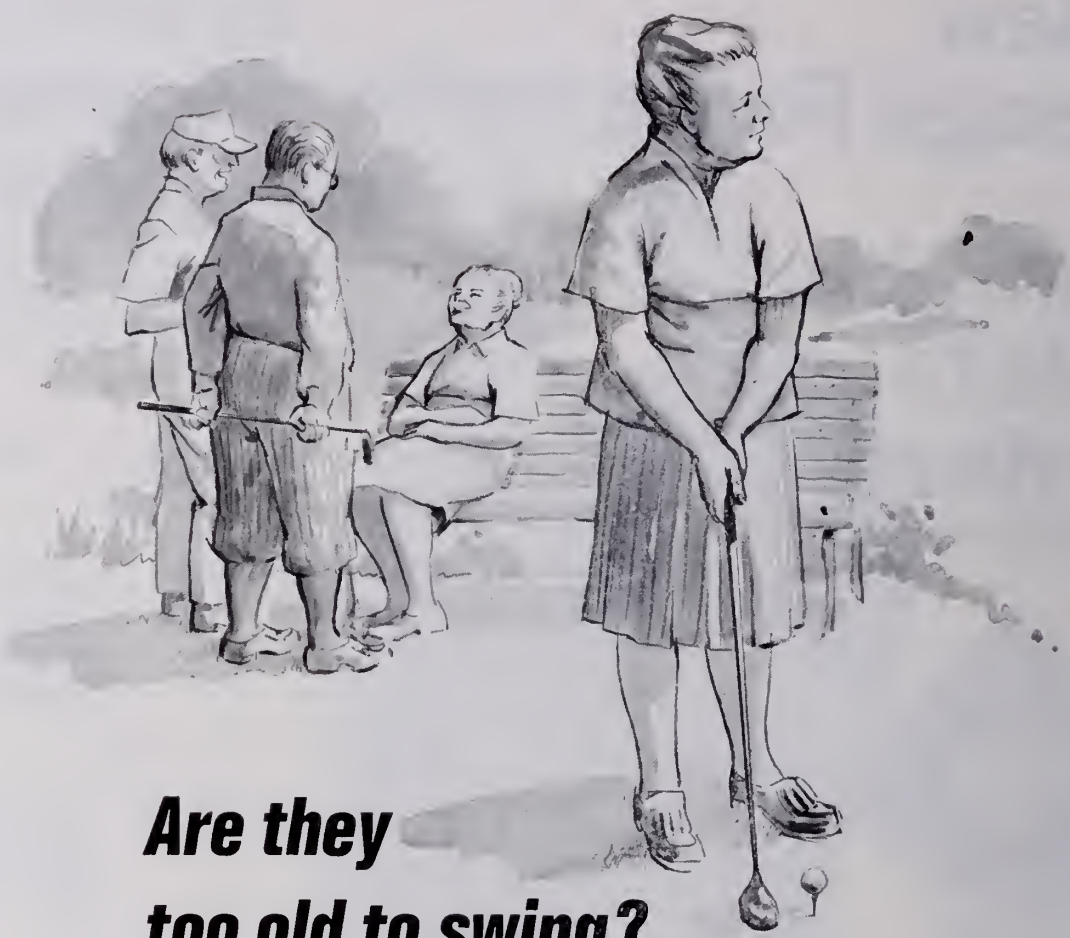
INDICATION | DOSAGE SCHEDULE

MINTEZOL® (Thiabendazole, MSD) has demonstrated effectiveness against a broad spectrum of nematode infestations, whether encountered singly or in combination. Dosages are weight related; therefore, a weight-dose chart is included in the Direction Circular for your convenience when writing a prescription. MINTEZOL should be given after meals if possible.

INDICATIONS	DOSAGE (1st Day)	ADDITIONAL REGIMEN	COMMENTS
Pinworm disease	Two doses of 1 tablet/50 lb	Repeat 7 days later	This regimen is designed to reduce the risk of reinfection. However, if not practical, repeat the regimen the next day.
Threadworm,* large roundworm,* hookworm,* and whipworm* disease	Two doses of 1 tablet/50 lb	Repeat the next day	Alternatively, a single dose of 2 tablets/50 lb may be given. However, a higher incidence of side effects should be expected.
Creeping eruption	Two doses of 1 tablet/50 lb	Repeat the next day	If active lesions are still present 2 days after completing this regimen, a second course is recommended.
Symptoms of trichinosis* during the invasive phase of the disease	Two doses of 1 tablet/50 lb	Repeat for 2 to 4 successive days	The optimal dosage for the treatment of trichinosis has not been established.

The recommended maximal daily dosage is 3 g (6 tablets).

*Clinical experience with thiabendazole for treatment of each of these conditions in children weighing less than 30 lb has been limited.



Are they too old to swing?

EACH TESTAND-B TABLET CONTAINS:

Ethinyl Estradiol	0.005 mg.
Methyltestosterone	1.25 mg.
L-lysine	100 mg.
Ferrous Nicotinate	17.85 mg.
Equivalent to Nicotinic Acid	12.5 mg.
Ferrous Iron	2.82 mg.
Vitamin A	2,500 U.S.P. Units
Vitamin D	250 U.S.P. Units
Thiamine Mononitrate	2.5 mg.
Riboflavin	2.5 mg
Ascorbic Acid	25.0 mg.
Folic Acid	0.125 mg.
Vitamin B-12	1.5 mcg.
Methionine	12 mg.
Choline Bitartrate	15 mg.
Inos.tol	10 mg
Calcium Pantothenate	2.5 mg.
Pyridoxine	0.25 mg
Copper (from Copper Sulfate)	0.25 mg.
Zinc (from Zinc Oxide)	0.25 mg.
Iodine (from Potassium Iodide)	0.075 mg.
Calcium (from Dicalcium Phosphate)	72.5 mg.
Phosphorus (from Dicalcium Phosphate)	55 mg.
Potassium (from Potassium Sulfate)	2.5 mg.
Manganese (from Manganese Sulfate)	0.5 mg
Magnesium (from Magnesium Sulfate)	0.5 mg.

As the "middle years" exact their metabolic toll, complaints are vague, but therapy can be specific.
Testand-B, as an anabolic stimulant in male and female climacteric, senile vaginitis, decreased muscle tone, protein depletion states, osteoporosis and loss of body mass, helps compensate for the metabolic changes of aging. The androgen/estrogen combination, plus the comprehensive nutritional complex provided by Testand-B, helps patients feel better physically and emotionally.

ACTION AND USES—*DOSAGE:* 1 tablet after breakfast and supper, or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. *PRECAUTIONS:* Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. *CONTRAINDICATIONS:* Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. *AVAILABLE:* Bottles of 30, 100, and 500 tablets.

Testand-B tablets

A hormonal, nutritional supplement

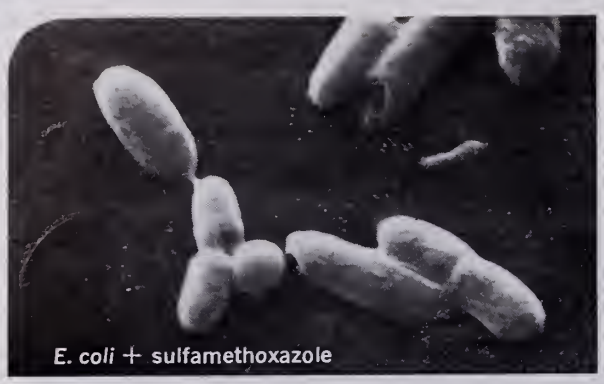
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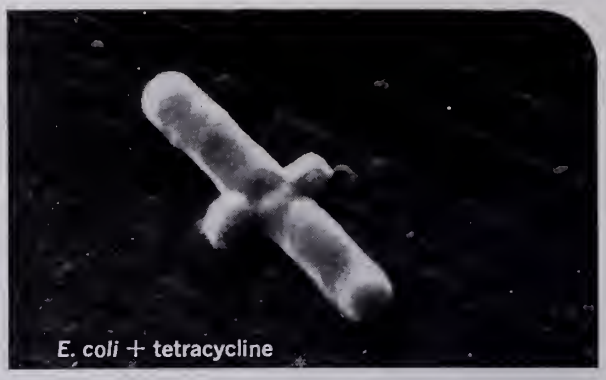
Encounter under the Scanning Electron Microscope



SEM reveals changes in *E. coli* exposed to antibacterial agents

The Scanning Electron Microscope (SEM) is the only instrument which gives 3-dimensional views on a microscopic level. This permits the surface morphology of microorganisms to be observed in detailed perspective. Changes in surface morphology of *E. coli* exposed to various antimicrobial agents are seen on the following page. An SEM photomicrograph of normal control *E. coli* appears above.









Different modes of antibacterial action — Similar changes in morphology

As part of a series of experiments,[1-3] strains of *E. coli* proven susceptible to each antibacterial agent were exposed to 1 MIC of the respective antibacterials for a three-hour period. Included were cell-wall-active drugs, ampicillin and cephalothin; a drug interfering with intracellular protein synthesis, tetracycline; and a chemical agent which acts by interference with para-aminobenzoic acid, sulfamethoxazole.

As seen above, elongation of the bacilli, mid-cell defects and spheroplast-like forms may be appreciated with the SEM technique. These changes in bacterial morphology were similar... regardless of the antibacterial agent used and irrespective of its mechanism of action.

"At present, the significance of these observations in clinical infection must be considered with caution, but it is hoped that these data will stimulate a reevaluation of present concepts of the nature and role of morphological variants of bacteria exposed to a variety of antibacterial factors."[2]

References:

1. Klainer, A. S.; Fass, R. J., and Perkins, R. L.: Scientific Exhibit presented at the 25th American Medical Association Clinical Convention, New Orleans, La., Nov. 28-Dec. 1, 1971.
2. Klainer, A. S., and Perkins, R. L.: *Antimicrob. Agents Chemother., 1*:164, 1972.
3. Klainer, A. S.: Data on file, Hoffmann-La Roche Inc., Nutley, N.J.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in acute, recurrent or chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) and in the absence of obstructive uropathy or foreign bodies.

***Note:* Since *in vitro* sulfonamide sensitivity tests are not always reliable, carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response. Add aminobenzoic acid to culture media of patients receiving sulfonamides. The increasing frequency of resistant organisms is a limitation of usefulness of antibacterial agents, including sulfonamides, especially in chronic or recurrent urinary tract infections.**

Blood levels should be measured in patients receiving sulfonamides for serious infections, since there may be wide variations with identical doses; 20 mg/100 ml should be the maximum total sulfonamide level, as adverse reactions occur more frequently at this level.

Contraindications: Sulfonamide hypersensitivity; infants less than 2 months of age (except adjunctively with pyrimethamin congenital toxoplasmosis); pregnancy at term and during nur period.

Warnings: Safe use in pregnancy has not been established, teratogenicity potential has not been thoroughly investigated. fonamides will not eradicate or prevent sequelae to group A stre coccal infections, *i.e.,* rheumatic fever, glomerulonephritis. De from hypersensitivity reactions, agranulocytosis, aplastic ane and other blood dyscrasias have been reported; early clinical s such as sore throat, fever, pallor, purpura or jaundice may indi serious blood disorders. Complete blood counts and urinalysis careful microscopic examination are recommended frequently ing sulfonamide therapy. Clinical data are insufficient on prolor or recurrent therapy in chronic renal diseases of children u 6 years.

Encounter in Clinical Practice

Control of primary bacterial offenders

Antibacterial Gantanol® (sulfamethoxazole) controls susceptible strains of *E. coli* and other gram-negative and gram-positive organisms often implicated in acute nonobstructed pyelonephritis and cystitis.

Prompt antibacterial blood and urine levels

In from 2 to 3 hours after the initial 2-Gm adult dose, antibacterial levels are present in both the blood and urine.

B.I.D./T.I.D. dosage for around-the-clock coverage

Subsequent 1-Gm doses provide up to 12 hours of antibacterial coverage. More severe u.t.i. may require a q. 8 h. dosage regimen. Either schedule provides coverage during the waking and sleeping hours—especially important during hours of sleep when normal urinary retention tends to favor bacterial proliferation.

Also effective in nonobstructed chronic and recurrent u.t.i.

It is not uncommon for the elderly and the debilitated to develop chronic and/or recurrent nonobstructed urinary tract infections such as pyelonephritis and cystitis. Such cases often respond satisfactorily to Gantanol. The increasing frequency of resistant organisms is a limitation of usefulness of antibacterial agents, including sulfonamides, especially in chronic or recurrent u.t.i.

Your Option: Tablets or Suspension

Either dosage form—the Tablets or the pleasant-tasting, cherry-flavored Suspension—can provide the dependable antibacterial activity necessary to control susceptible nonobstructed cystitis and pyelonephritis. Symptomatic improvement may usually be expected in 24 to 48 hours. The usual precautions with sulfonamide therapy should be observed, including adequate fluid intake. Gantanol (sulfamethoxazole) is generally well tolerated with relative freedom from complications; the most common side effects are nausea, vomiting and diarrhea. Frequent c.b.c.'s and urinalyses with microscopic examination are recommended.

In nonobstructed cystitis and pyelonephritis due to susceptible organisms

Gantanol®
(sulfamethoxazole)
Basic Therapy

Precautions: Use with caution in patients with impaired renal hepatic function, severe allergy, bronchial asthma and in glucose-phosphate dehydrogenase-deficient individuals. In the latter, dose-lated hemolysis may occur. Maintain adequate fluid intake to revent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* agranulocytosis, aplastic emia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, poprothrombinemia and methemoglobinemia; *allergic reactions:* ythema multiforme (Stevens-Johnson syndrome), skin eruptions, idermal necrolysis, urticaria, serum sickness, pruritus, exfoliative rmatitis, anaphylactoid reactions, periorbital edema, conjunctival d scleral injection, photosensitization, arthralgia and allergic myo-rditis; *gastrointestinal reactions:* nausea, emesis, abdominal pains, patitis, diarrhea, anorexia, pancreatitis and stomatitis; *C.N.S. re-tions:* headache, peripheral neuritis, mental depression, convul-ons, ataxia, hallucinations, tinnitus, vertigo and insomnia; and *iscellaneous reactions:* drug fever, chills, toxic nephrosis with oli-uria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide and thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age, except adjunctively with pyrimethamine in congenital toxoplasmosis. Usual dosage is as follows:

Adults—2 Gm (4 tabs or teasp.) initially, then 1 Gm (2 tabs or teasp.) *b.i.d.* or *t.i.d.* depending on severity of infection. *Children*—0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, followed by 0.25 Gm/20 lbs (½ tab or teasp.) *b.i.d.* Maximum dose for children should not exceed 75 mg/kg/24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

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when your angina* patient is on vacation... will his medication stop working too?

unlike sublingual nitroglycerin–

ISORDIL® SUBLINGUAL
(ISOSORBIDE DINITRATE)

SUBLINGUAL TABLETS: 2.5 mg. and 5 mg.

ready to work every time it's needed

- **STABLE**—potency not markedly affected by humidity or storage (sublingual nitroglycerin is known to be unstable enough to require careful packaging and storage to ensure full potency, even during relatively short periods[1])
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- **LONG LASTING**—effect lasts up to 2 hours (compared to nitroglycerin which maintains its effect for only 20 or 30 minutes)

***Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indication as follows:
"Probably" effective: When taken by the sublingual route, Isordil Sublingual is indicated for the treatment of acute anginal attacks and for prophylaxis in situations likely to provoke such attacks.
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Contraindication: Idiosyncrasy to this drug.

Warnings: Data supporting the use of nitrites during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

Precautions: Tolerance to this drug and cross-tolerance to other nitrites and nitrates may occur.

Adverse Reactions: Cutaneous vasodilation with flushing. Headache is common and may be severe and persistent. Transient episodes of dizziness and weakness as well as other signs of cerebral ischemia associated with postural hypotension may occasionally develop. This drug can act as a physiological antagonist to norepinephrine, acetylcholine, histamine, and many other agents. An occasional individual exhibits marked sensitivity to the hypotensive effects of nitrite, and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration and collapse) can occur even with the usual therapeutic dose. Alcohol may enhance this effect. Drug rash and/or exfoliative dermatitis may occasionally occur.

Consult direction circular before prescribing.

1. Edelman, B.A., Contractor, A.M., and Shangraw, R.F.: The stability of hypodermic tablets of nitroglycerin packaged in dispensing containers, J. Amer. Pharm. Ass. NS11:30 (January) 1971.

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Orinase should not be used: when diabetes is complicated by acidosis, ketosis, or coma, or when a history of repeated bouts of acidosis or coma is obtained; in the presence of other acute complications such as fever, severe trauma, or infections; and in patients with severe renal insufficiency. Insulin is indicated in these circumstances.

Pregnancy Warning: The safety and usefulness of Orinase during pregnancy has not been established either from the standpoint of the mother or the fetus. Animal studies have demonstrated feticidal and teratogenic effects of doses of 1,000-2,500 mg./kg./day, but application to human subjects unknown. Therefore, Orinase is not recommended for the pregnant diabetic, and when administering Orinase to women of childbearing age, these facts should be borne in mind.

Precautions: Diagnostic and therapeutic measures necessary for optimal control with insulin are also necessary with Orinase. The patient on Orinase must be fully instructed: about the nature of his disease; how to prevent and detect complications; how to control his condition; not to neglect dietary restrictions, develop a careless attitude or disregard instructions relative to body weight, exercise, personal hygiene, and avoidance of infection; how to recognize and counteract impending hypoglycemia; how and when to test for glycosuria and ketonuria; how to use insulin; and to report to the physician immediately if he does not feel as well as usual.

Caution, very close observation, and careful adjustment of dose are necessary when: insulin is withdrawn during the trial period in order to avoid ketosis, acidosis, and coma; thiazide diuretics are administered which may result in aggravation of diabetic state and increased tolbutamide requirement, temporary loss of control, or even secondary failure; treating patients with impaired hepatic and/or renal function and debilitated, malnourished, or semistarved patients in order to avoid severe hypoglycemia which may require corrective therapy over several days; and treating patients with severe trauma, infection, or surgical procedures where temporary return to insulin or addition of insulin may be necessary. Response to tolbutamide is diminished in patients receiving therapy with beta blocking agents.

As some diabetics are not suitable candidates, it is essential that the physician familiarize himself with the indications, limits of application, and selection of patients for therapy.

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cian daily, and during the first month report at least once weekly for physical examination and definitive evaluation. After a month, examinations are recommended monthly or as indicated. Appearance of ketonuria, increase in glycosuria, unsatisfactory lowering or persistent elevation of blood sugar, or failure to obtain and hold clinical improvement indicate nonresponsiveness to Orinase (tolbutamide). Orinase does not obviate need for maintaining standard diet regulation. Uncooperative patients should be considered unsuitable for therapy. Prescriptions should be refilled only on specific instruction of physician. In treating mild asymptomatic diabetic patients with abnormal glucose tolerance, glucose tolerance tests should be obtained at three- to six-month intervals. Orinase is not an oral insulin or a substitute for insulin and must not be used as sole therapy in juvenile diabetes or in diabetes complicated by acidosis or coma where insulin is indispensable.

If phenformin is prescribed in combination with Orinase, appropriate package literature should be consulted.

Adverse Reactions: Severe hypoglycemia, though uncommon, may occur and may mimic acute neurologic disorders such as cerebral thrombosis. Certain factors such as hepatic and renal disease, malnutrition, advanced age, alcohol ingestion, and adrenal and pituitary insufficiency may predispose to hypoglycemia and certain drugs such as insulin, phenformin, sulfonamides, oxyphenbutazone, salicylates, probenecid, monamine oxidase inhibitors, phenylbutazone, bishydroxycoumarin, and phenyramidol may prolong or enhance the action of Orinase and increase risk of hypoglycemia. Orinase long-term therapy has been reported to cause reduction in RAI uptake without producing clinical hypothyroidism or thyroid enlargement and at high doses is mildly goitrogenic in animals. Photosensitivity reactions, disulfiram-like reactions after alcohol ingestion, and false-positive tests for urine albumin have been reported.

Although usually not serious, gastrointestinal disturbances (nausea, epigastric fullness, and heartburn) and headache appear to be dose related and frequently disappear with reduction of dose or administration with meals. Allergic skin reactions (pruritus, erythema, urticaria, and morbilliform or maculopapular eruptions) are transient, usually not serious, and frequently disappear with continued administration. Orinase should be discontinued if skin reactions persist. Recent reports indicate that long-term use of Orinase has no appreciable effect on body weight.

Orinase appears to be remarkably free from gross clinical toxicity: crystalluria or other renal abnormalities have not been observed; incidence of liver dysfunction is remarkably low and jaundice has been rare and cleared readily on discontinuation of drug (carcinoma of the pancreas or other biliary obstruction should be ruled out in persistent jaundice); leukopenia; agranulocytosis; thrombocytopenia; hemolytic anemia; aplastic anemia; pancytopenia; and hepatic porphyria and porphyria cutanea tarda have been reported.

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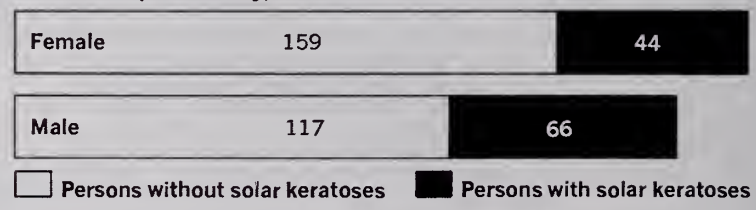
What it means to live and work in Tipton County, Tennessee

Persons who are white and over 40 have one chance in four of having solar keratoses... which may be premalignant

An epidemiologic study* conducted in Tipton County, Tennessee, revealed that 28.5% of white persons over 40 had solar keratoses; most had multiple lesions. Cluster sampling projected an estimated prevalence of 32.5% for white males and 19.5% for white females.

Though this is an unusually high percentage of affected persons, these lesions can occur in any white population, wherever people work or play out of doors.

Prevalence of solar keratoses in white persons over 40 in Tipton County, Tennessee



*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.



Solar, actinic, senile keratoses

Called by many names, the typical lesion is flat or slightly elevated, brownish or reddish in color, papular, dry, adherent, rough, sharply defined; usually multiple lesions, chiefly on exposed portions of the skin.

Sequence/selectivity of response

Erythema in areas of lesions may begin after several days of therapy; height of reaction (only in affected areas)* usually occurs within two weeks, declining after discontinuation of therapy. Since this response is so predictable, lesions that do not respond should be biopsied to rule out the presence of a frank neoplasm.

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Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

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Medical News

Mount Sinai Gets Grant

The Mount Sinai Medical Center on Miami Beach has received a five-year, $200,000 pulmonary disease training grant from the National Heart and Lung Institute. This raises the total of grants and contracts the Pulmonary Disease Department has received to more than $320,000.

ACP Admits 5 Floridians

Five Florida physicians are among 283 doctors who recently were granted Fellowship in the American Colleges of Physicians.

The Floridians are Robert R. Teahan, M.D., of Bradenton; George J. Caranasos, M.D., of Gainesville; George W. Counts, M.D., of Miami; and John W. Lister, M.D., and Clyde D. Schoenfeld, M.D., both of Miami Beach.

Tampa Physician Elected

Richard T. Farrior, M.D., of Tampa has been re-elected as Southern Regional Vice President of the American Academy of Facial Plastic and Reconstructive Surgery.

Dr. Farrior and other officers were elected during the Academy's Eighth Annual Scientific Meeting in Palm Beach. The Academy consists of about 950 otolaryngologists who perform head and neck plastic surgery.

ACA Fellow

Rex E. Stubbs, M.D., of Fort Myers, has been certified as a Fellow of the American College of Anesthesiologists.

New Crippled Children Chief

Lewis Cosby, M.D., has been appointed Chief of the Bureau of Crippled Children in Florida's Division of Vocational Rehabilitation, Department of Health and Rehabilitative Services.

A pediatrician with 24 years of practice, Dr. Cosby comes to Florida from Johnson City, Tenn., to succeed F. Edwards Rushton, M.D., who resigned to return to private practice in Sarasota.

Dr. Cosby is a graduate of the University of Virginia School of Medicine and a residency at Johns Hopkins Hospital. He is a Diplomate of the American Board of Pediatrics and a Fellow of the American Academy of Pediatrics. He assumed the Florida position on June 1.

Acting Dean Appointed at Florida

Herbert E. Kaufman, M.D., Professor and Chairman of the Department of Ophthalmology at the University of Florida College of Medicine, has been named Acting Dean.

The appointment was announced by Edmund F. Ackell, M.D., Vice President for Health Affairs. Dr. Kaufman, who will continue as Chairman of Ophthalmology, succeeds Emanuel Suter, M.D., who resigned and joined the Association of American Medical Colleges.

Dr. Kaufman's "administrative abilities and his skills and productivity as clinician, investigator and teacher are well known in this state and in the nation," Dr. Ackell remarked. "He has the full support of this administration to serve as acting dean until a permanent dean has been secured."

A graduate of Harvard Medical School, Dr. Kaufman joined the Florida faculty 10 years ago, organizing the Division of Ophthalmology and developing it into a major unit of the College. He is a member of the Alachua County Medical Society and the Florida Medical Association.

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JFMA
THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.
AUGUST, 1972 • VOLUME 59 • NUMBER 8

MEDICAL HISTORY ISSUE

The Journal acknowledges with pride the fifth straight year that Dr. William Straight, Instructor in History of Medicine at the University of Miami, has written and compiled the papers for the August issue. In 1965, when the first historical issue was conceived, Dr. Straight was a contributing author as well as in 1966 and 1967; then becoming the historical editor in 1968 and in each subsequent history issue. These editions have gained more than statewide interest, for every year requests are received for copies from history buffs all over the country.

With this publication we would encourage our readers over the state to probe their local areas for medical history as undoubtedly Dr. Straight is already collecting material for another volume next year. He also has been given the job of writing the historical data for the 100th anniversary of the Florida Medical Association in 1974 and has been asked by the Department of HEW to provide the history of Medicine in Florida during 1776 to commemorate our nation's bicentennial birthday. Having served a number of years as chairman of the FMA Archives Committee, sitting on FMA reference committees and serving as delegate from Dade County, he is a perennial collector of medical history in Florida, and somehow finds time to practice internal medicine, being certified in his specialty.

About Our Authors

Contributing to this year's historical issue are several newcomers to the Journal of the Florida Medical Association and one or two "old faces."

This issue begins with portraits and commentaries upon two outstanding Yellow Fever Fighters by Dr. Fredrick Eberson of St. Petersburg. Dr. Eberson, Retired Clinical Professor of Community Medicine, University of Kentucky, Lexington, has contributed several articles and books on medical history in the United States over the past years. His most recent contribution is a delightful volume, "Portraits: Kentucky Pioneers in Community Health and Medicine." Since coming to Florida he has been actively engaged in researching Florida medical history.

Our second article is an informative sketch of the history of the Key West Marine Hospital by Dr. Alvan G. Foraker. Dr. Foraker, Pathologist at the Baptist Memorial Hospital, became interested in the history of the Key West Hospital while stationed there during World War II. His article reflects both the product of his research and his personal experiences.

Next is a vivid personal reminiscence of Key West medicine during the years 1941 to 1943 by Dr. Richard L. Pearse. Dr. Pearse, now engaged in the private practice of obstetrics and gynecology in Durham, North Carolina takes the reader to where the action was.

Following Dr. Pearse's reminiscence is a delightful article by the former Managing Editor of the Journal of the Florida Medical Association, Mr. Eugene Nixon. Mr. Nixon presents a wealthy patent remedy king, Dr. Ray V. Pierce, whose nostrums netted him more than a million dollars and the lovely, unspoiled St. Vincent's Island off the Florida Panhandle which is now a wildlife refuge.

The issue winds up with an article by myself about Miami's pioneer physician, Dr. James M. Jackson Jr. Jackson was clearly a leader in community and medical circles and served as President of the Florida Medical Association in 1905.

May you find this issue pleasant and informative.

WILLIAM M. STRAIGHT, M.D.,
ASSISTANT EDITOR

Yellow Fever Fighters

Dr. Joseph Y. Porter
Dr. Isaac Hulse

Frederick Eberson, Ph.D., M.D.

Introduction

In the battle against yellow fever, four physicians in Florida played a significant part—Dr. J. Y. Porter, Dr. Isaac Hulse, Dr. R. D. Murray and Dr. R. B. Hargis. Dr. Hulse and Dr. Porter, one in the service of the U. S. Navy and the other in the Army, were ahead of their times in important fields of medicine. Significantly, through fate and circumstance, both were thrown into early contact with yellow fever, and the study of it became their life work.

Dr. Hulse pioneered with success that confounded his contemporaries the treatment and management of yellow fever, boldly shunning the currently popular methods of bleeding and purging. He also had advanced ideas regarding the control of epidemic yellow fever. Dr. Porter pioneered the control of communicable diseases and application of newer knowledge of yellow fever etiology to its prevention and control. As Florida's first State Health Officer, he introduced new ideas concerning the people's health and practice of preventive medicine.

It is of interest, as one reads the life work of these two great men, to consider their contrasting backgrounds, origins and family history and most important the times in which they lived and the current state of medical science. In contrast with Dr. Porter, who was born a half century later, Dr. Hulse did not live to hear about the scientific discoveries that would revolutionize medical thinking. His world was plagued with miasmatic contagion and curative medicine harking back to the days of medieval barber surgeons. Yet he rose to eminence by approaching infectious disease problems and therapeutic medicine with a fresh, original viewpoint.

Dr. Joseph Y. Porter, 1847-1927

Who was this man, a merchant's son who became Florida's first State Health Officer, pioneered in preventive medicine, and helped transform a mosquito-infested land plagued with yellow fever, malaria and other contagious diseases into a wholesome, habitable place to live? Whatever his calling, no man could have done as much unless his first thoughts were for mankind.

Dr. Joseph Yates Porter was such a person (Fig. 1). As a man of action he recognized that, with changing times, problems change, and measured up to greatness because of qualities that enabled him to communicate at all levels a sense of the need of the times. And he had the requisite ability to bring about change when the time was right.

In his early development Dr. Porter's heritage played a very significant part. His grandfather and grandmother were Thomas Mann and Susan Randolph of Virginia. His father, born in Charleston, South Carolina, in 1817, moved late in the 1830's to Key West and became a well-to-do merchant. Here, in 1845, he married Mary Ann Randolph, daughter of Captain Thomas Mann Randolph, who was stationed in the port of Key West until his death, a victim of yellow fever. After a brief visit to Charleston early in 1847, Porter's return passage was delayed by a severe

Dr. Eberson is Clinical Professor (Emeritus) of Community Medicine, University of Kentucky Medical Center, Lexington.

coastal hurricane. During this wait he died of yellow fever only a few months before his son and namesake, Joseph Yates Porter, was born on October 21.

Joseph's boyhood years were spent in Key West where yellow fever struck with regularity. He saw at first hand the ravages of this pestilence and the annual preparations made by his mother and grandmother Randolph for flight to another home in Virginia for refuge. It was their custom to return to Key West late in the fall when the mysterious cause of yellow fever would have been blown away by the chill winds.

Orphaned once more by the death of his mother, young Porter, at age 13, now became the ward of grandmother Randolph. Shortly afterward the Civil War came to Florida and northern troops occupied the port of Key West. Mrs. Randolph, an avowed sympathizer with the Confederacy, was ordered to leave the city.

Of Porter's early education, little has been noted other than enrollment at a school in northern New York and soon afterward at St. Mary's Hall in Burlington, New Jersey, where his mother had been a student. At the age of 23, in 1870, he graduated with the degree, Doctor of Medicine, from Jefferson Medical College, Philadelphia. In the same year he was appointed Acting Assistant Surgeon in the United States Army and stationed at Fort Jefferson in Dry Tortugas, where he spent three and a half years.

His first intimate experience with yellow fever as a patient was invaluable to Porter, then a young medical student. He was stricken with the disease during the summer of 1867 at the height of an epidemic which started at Fort Jefferson. In later years he would write about this as an outstanding commentary on the ability of the human system to rid itself of an incredible amount of useless, ignorant medication and yet survive. Shortly before completing his tour of duty at Tortugas in 1873, another outbreak of yellow fever gave further impetus to his studious interest in the disease.

In Jacksonville, Dr. Porter began his professional career and made history during the memorable epidemic of 1888. It was a time of panic in the streets and uncontrollable dread for personal safety to the complete neglect of sick and helpless members of the family. So widespread was the unwarranted fear of contagion by inanimate objects (fomites) that daily happenings seemed like pages from the history of plague pestilence in the Middle Ages.

Depopulation of the city and establishment of refugee camps brought on huge problems of relief and an acute shortage of medical and nursing care. In the midst of this chaotic state of affairs, Dr. Porter, who was in Key West at the time, received an urgent call for professional help from the Duval County Board of Health. Since the Board had no full-time personnel, the Marine Hospital Service offered the services of some of its staff and an "Auxiliary Sanitary Association" was set up to manage general relief and what might be called "public relations."

With Dr. Porter's arrival, it was agreed by mutual consent that all medical and relief measures be coordinated within one "government relief service" and that he be in charge of this program. One function was to provide medical and nursing care for the needy. Befitting his special interest in disease control, he took on full responsibility for directing fumigation of every city dwelling where a case of yellow fever had been found. To his lot also fell the burden of care and distribution of funds, clothing and food.

While occupied with these urgent demands of official duties, he did not give up his practice as a physician. The executive committee of the Jacksonville Sanitary Association provided two of the fastest horses in the city in order that he

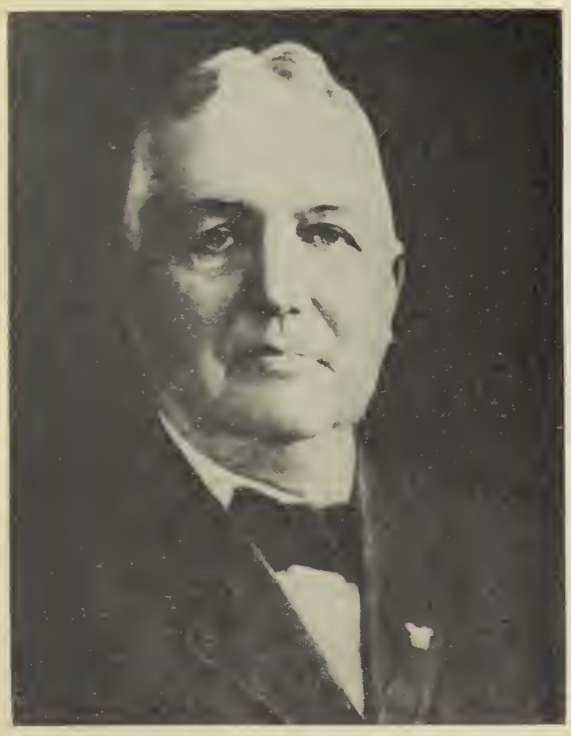


Fig. 1.—Dr. Joseph Y. Porter, Florida's First Health Officer.

Photograph courtesy of Dr. Wilson T. Sowder, Director, Division of Health, State of Florida.

might carry on his professional work. For weeks he labored without respite from 20 to 22 hours daily.

Toward the latter part of that month, at a special meeting of the Jacksonville Auxiliary Sanitary Association, Dr. Porter gave his final reports and informed the Association and the Duval County Board of Health that he had submitted to the Surgeon General a request for relief from his duties in order to return to active practice at his home in Key West. At the close of the meeting, he was presented with an engraved gold Repeater watch by the Jacksonville Auxiliary Association as a token of public appreciation for his gratuitous services. This timepiece was no ordinary one; it was truly a conversation piece for all time (Fig. 2).

But what appeared to be a parting goodbye to an honored public servant proved to be only a temporary lapse in his devotion to his chosen field. Two years before, in his address as president of the Florida Medical Association at the annual meeting in St. Augustine in May, 1887, Dr. Porter had expressed the hope that the legislature then in session would form a State Board of Health; a Board with sufficiently broad and inclusive powers to meet the most exacting requirements of public health and sanitary science.



In recognition of his gratuitous services to the city of Jacksonville during the yellow fever epidemic of 1888, Dr Joseph Y. Porter was presented the above pictured Swiss watch.

The gold timepiece is an Audemar minute repeater in a plain case having on the smooth face the letter "P" encrusted with diamonds. The inside engraving, completed in New York, states: "Presented to Joseph Y. Porter, M.D., Surgeon-in-Charge, United States Government Relief Measures, by the Jacksonville Auxiliary Sanitary Association in recognition of valuable services to the citizens of Jacksonville, Florida, during the yellow fever epidemic of 1888."

The cable link chain has a gold anchor bar from which hangs a pendant in the shape of a gold life preserver encircling a star of diamonds. On the charm face there is inscribed: "In recognition of Services, Epidemic, 1888." On the opposite side there is written, "Jacksonville Auxiliary Sanitary Association."

The latter words encircle the initial "P" set with rubies and diamonds. The life preserver charm was fashioned after a life preserver borrowed for this purpose from the yacht, "Dauntless" once owned by James Gordon Bennett. The watch strikes the minutes, quarters and hours.

Caption reproduced from Florida Health Notes, September, 1959.

He related many unpleasant past experiences, showing how the lack of complete authority had continually led to ineffectual planning and directing by local boards of health, and frequently to personal insult and bitter feelings. In this context, Dr. Porter also emphasized the necessity for establishing a Board having statewide jurisdiction, the lack of which made the existing county health boards entirely inadequate.

Central State Health Department

Joining forces with Dr. John Crews Pelot, Chairman of the Committee on Public Health, who had in the meantime introduced the State Board of Health bill into the House, Dr. Porter laid before Governor Edward Perry, "the urgent necessity for a central State Health Department or Bureau." But this bill fell through, even as yellow fever already epidemic in Key West had moved to Tampa in the fall of 1887, traveled upstate in sporadic outbreaks, and then gone on a rampage at Jacksonville in August, 1888.

Such a failure was not without precedent for as early as 1873 a bill of this nature, introduced in the legislature to provide the sum of $200 for the purpose, was turned down because of the "exorbitant" request. Many other efforts failed until 1885 when at the insistence of Dr. John P. Wall of Tampa, then a legislative representative from Hillsborough County, the framers of the State Constitution inserted an article authorizing establishment of a state board of health. Yet despite this constitutional provision of 1885, referred to by Dr. Porter as a "lasting memorial to Dr. Wall, a man far ahead of his times," and the persuasive efforts of the president of the Florida Medical Association, no action was taken.

During those fall months of 1888, a political campaign year, Francis P. Fleming, then a candidate for governor of Florida, decided to do something about the chaotic condition of affairs and the desperate need for harmoniously coordinated sanitary knowledge. Difficulties experienced in travel from one county to another hindered the political campaign. Candidates were at the mercy of quarantine regulations set up by individual county health boards. Often rumors and fear prevented by armed force movement from one county to another. This type of "shotgun quarantine" —appropriately named—unbelievable as it might seem, threatened Dr. Porter if he attempted to pass on a railroad engine through one of the counties neighboring on Duval to visit the sick

at a small settlement. "He was informed that he would be shot at because he had been in contact with yellow fever patients in Jacksonville."

In his first official act, after taking the oath of office as governor, Fleming called a special session of the legislature on Feb. 5, 1889 to act on the earlier constitutional provision which would remedy the shocking conditions he had experienced. Fifteen days later a bill was passed and signed by the governor, creating a State Board of Health; an Act designed to promote strict controls for yellow fever, smallpox and cholera, other infectious diseases and the general supervision of the public health. A three-member board, promptly appointed by the governor, immediately chose Dr. Porter as State Health Officer.

At the outset, the primary object of the Board of Health was to prevent another invasion of yellow fever from the port cities where it was periodically introduced. Under Dr. Porter's leadership, the farseeing principles of maritime sanitation adopted by Florida in 1889 became the essence of the U. S. Quarantine Board Rules and Regulations drawn up in 1893.

In his day there were still some die-hard sanitarians who clung to an old theory that yellow fever was brought into a community with clothing, bedding or freight in any form. Dr. Porter, who was familiar with the recently published experiments of the U. S. Army Yellow Fever Board, opposed this erroneous idea and declared that yellow fever could not be spread by inanimate objects (fomites); nor could it be brought in by baggage, a preposterous notion already disproved by the studies on survival of infected mosquitoes confined in closed spaces for a long time without air or food.

On the matter of contagion and quarantine, he was most emphatic in stating the new rules and regulations of the United States government that were now based on the epoch-making discovery of the cause of the spread of yellow fever. Maintaining expensive quarantine procedures previously established to conform with the theory of infection by fomites was, for the most part, shown to be unnecessary.

Vessels from ports known or supposed to be infected with yellow fever were to be detained at a government or state quarantine station. They were to be held long enough to permit thorough fumigation of empty holds, living quarters of passengers and crew, and flushing of the bilges after mercurial treatment. As an added precaution, the vessel was kept under observation of the quarantine officer at the port of arrival five days after completing fumigation.

With habitual foresight, Dr. Porter stressed the risk entailed in trade relations with southern countries and domestic ports during the summer season. Southern medical practitioners, he felt, also should keep in mind the importance of keeping all nonsurgical fever cases protected by netting against mosquito bites, not only during summer but all seasons, since the fever might be malarial.

By now it must have been obvious even to ultraconservatives that controlling a yellow fever epidemic, the duty of the health authorities, required systematic quarantine procedures. To this end, Dr. Porter suggested a sanitary cordon, administered and controlled by an officer of the state militia acting under direct instructions from the state health authorities. This would insure an effective means of checking or suppressing the disease within the area, and excluding the introduction of a nonimmune population from outside. Moreover, such a procedure would not imply indiscriminate restrictive quarantine. Rather, persons known to be definitely immune to yellow fever would be allowed freedom of movement within the infected territory, and in leaving the same state or traveling to other states.

Modern Public Health Organization

Completion of the first 12 years of Dr. Porter's service as State Health Officer set the stage for the creation of bureaus within the State Board of Health and the beginning of modern public health organization in Florida. All his notable achievements of the next 16 years were due in great measure to his gift of translating knowledge into action.

Although his farsighted management and solution of the quarantine problems posed by the Jacksonville epidemic bordered on the prophetic, they were no less significant than the progressive methods he introduced for controlling the Pensacola outbreak of 1905. By dint of great efforts directed to careful screening and destruction of adult mosquitoes to prevent their breeding in the city, Dr. Porter kept the epidemic from spreading beyond Pensacola to surrounding communities.

He also emphasized the value of mosquito control by showing that yellow fever did not spread when hospital cases were isolated in carefully screened wards, even though staffed by nonimmune nurses who also took care of patients

with other febrile diseases. In effect, Dr. Porter had demonstrated for the first time in Florida, if not in the United States, the truth of the internationally accepted theory of yellow fever transmission by the *Aedes aegypti* mosquito.

Next to yellow fever, epidemic smallpox was a worrisome problem. As customarily practiced, control methods provided for isolation of known cases and contacts in special hospitals or "pest houses" built on land distant from dwellings. In 1904 the State Board of Health incurred a greater expense for control of smallpox than for any other contagious disease. In that year, the cost of caring for nearly 700 cases amounted to slightly less than $7 for each patient. An official report stated that the management consisted of "treatment, medicine, food, nurses, guards and substantial disinfection."

Following a major epidemic of smallpox in Florida in 1912 with over 3,000 reported cases, there was a progressive decline in the number of cases in subsequent years. This was due primarily to the increased approval of vaccination as a preventive against the disease.

A campaign for compulsory vaccination was initiated by Dr. Porter as early as 1901. That year he took leave without pay to attend the session of the Legislature, hoping to obtain passage of a bill requiring vaccination. The measure was defeated, but Dr. Porter stuck to his guns and the State Board of Health then announced it would vaccinate all persons wishing to take advantage of protection against smallpox. Moreover, all houses where a case of smallpox was found would be placarded to warn everyone to keep out.

Triumph of Educational Reasoning

From the very beginning of his career in Florida, this "triumph of educational reasoning" exemplified Dr. Porter's method of educating the public in health matters. It "offered the most logical approach to the limitation of disease and deferment of death." All physicians were strongly urged to assist in the program by telling their patients how proper sanitation could prevent disease and prolong life.

Extension of this plan to promote understanding and cooperation in problems concerning the people's health took various forms. Within a few years after the State Board of Health was established, Dr. Porter's "Florida Health Notes," which had first appeared in 1892, now became the official health journal. Under his authorship and editorial supervision it contained articles on divers problems affecting the state.

With the addition of a corps of district assistants, he initiated an educational program which laid the groundwork for satisfactory isolation, treatment and control of communicable diseases. By means of lectures, pamphlets, bulletins and illustrated placards, the public was taught how to keep their health or suffer the dire consequences of its neglect.

A later means of getting the message to people was the "Educational Health Exhibit Train." The plan, like that operating in Louisiana, was conceived by Dr. Porter in 1915. Through an act of the state legislature and the Interstate Commerce Commission, three sleeping cars obtained from the Pullman Company were furnished and remodeled at a total cost of $8,200 (considered a big drain on the budget). One car was equipped for living quarters and the other two contained health displays and motion picture equipment. The train was hauled without charge by the railways and run through Florida on a regular schedule. Following Dr. Porter's retirement in 1917, the health train plan was abandoned and several years later the cars were sold to a carnival company.

Along with current health problems and diseases, Dr. Porter recognized the urgent need for compiling accurate statistics on deaths, with their causes, and births and marriages. After a three-year trial of the regulations first introduced by the State Board of Health in 1889 proved woefully inadequate, he started a vigorous, intensive campaign directed to all physicians and midwives. The new regulations required that reports of births and deaths be sent directly to the State Board of Health instead of as heretofore to county health boards. However, after an auspicious beginning, this effort, like several others, was unsuccessful. Finally, in 1915, the legislature enacted the Model Vital Statistics Law which had the unqualified approval of the Bureau of the Census, Children's Bureau, American Medical Association and other health organizations. In 1918, a qualified statistician was appointed director of the Bureau of Vital Statistics, and a year later Florida was admitted to the Death Registration Area of the United States by the Federal Census Bureau.

Even before the threat of yellow fever had subsided, Dr. Porter was deeply concerned with tuberculosis which he considered a major problem. As the State Health Officer, his annual re-

ports to the governor and the Board contained a wealth of information on the subject and useful suggestions for remedying the situation. In 1905 he stressed the need for isolating tuberculous patients and a large state institution for the care of active infectious cases. Although the legislature in 1909 finally authorized the State Board of Health to acquire and maintain institutions for indigent tuberculous patients, various obstacles over the next four years prevented the implementation of this plan.

Dr. Porter then suggested the employment of trained nurses to search for and visit active pulmonary cases and their families at home, to assist the sick and give instruction in the care and prevention of the disease. After two years he had a staff of 13 nurses, only two short of the number originally requested, for district nursing service. At first limited to the antituberculosis campaign, the service was promptly broadened to include all forms of public health activity.

With the ghost of spontaneous generation finally laid to rest and the microbial cause of many communicable diseases now established, Dr. Porter in 1910 made a well-timed proposal to organize a public health laboratory for bacteriological and chemical examinations. Had not the recommendation been delayed by a disastrous fire, the Board of Health would have given its immediate approval. At the Board of Health meeting the following year, Dr. Porter again emphasized the need of a laboratory to help physicians and local health officers diagnose certain diseases and detect the presence of others. Such service would also include the examination of water supplies and allied problems of public health and sanitation. At this meeting, without further delay, the laboratory was authorized and its phenomenal growth during and since Dr. Porter's tenure of office gave further proof of his leadership.

From its earliest days, the State Board of Health was faced with the problem of animal diseases, notably glanders and rabies. Observing the significant relationship of animal diseases to man, Dr. Porter recommended establishment of a Veterinary Division. In 1903 and 1904, through a cooperative arrangement between the University of Florida and the State Board of Health, the Division of Veterinary Medicine developed a comprehensive program. This included, besides glanders and rabies, the control of hog cholera, tuberculosis in cattle and Texas fever. For the purchase and free distribution of hog cholera vaccine unusually large sums of money were spent during the years 1911 to 1915 and a program of tuberculin testing in cattle was also initiated. But the control of Texas fever now became Dr. Porter's main concern as he called attention to the economic significance of this disease, which was being transmitted to healthy cattle through infected ticks.

This discovery, made by Dr. Theobald Smith during the last decade of the 19th century, was for a time ridiculed in this country as unadulterated fantasy and was viewed with skepticism by many veterinarians.* Dr. Porter, nevertheless, contended that only an energetic program of tick eradication would permit the importation of breeding cattle from outside areas to improve Florida's breed and so develop a prosperous industry. This campaign met with considerable opposition on the part of cattlemen, who even resorted to violence and acts of vandalism to "protect" their livestock and personal liberty. However, after several counties had accepted the State Board of Health recommendations and were found completely rid of the pest, permission was then granted to ship cattle anywhere in the country. Other counties soon followed their example and the battle was won.

Referring to his discovery of hereditary transmission of disease in insects to animal hosts, Dr. Theobald Smith made the terse remark, "no ticks —no Texas fever." Oddly enough, he had based his work on the popular theory of Texas ranchers and cattlemen who believed that Texas fever ("tick fever") was related in some way to the presence of cattle ticks. Yet, while these Texans from the very beginning cooperated in the field experiments, the Florida cattlemen, more than two decades later, were neither ready nor willing to accept the benefits of this discovery.

End of Golden Era

With the approach of World War I, Dr. Porter's tenure as State Health Officer came to a close marking the end of a golden era of progress. During his last four terms in office, 1901-1917, the budget had expanded threefold to a total of $165,000 of which about one half was allotted for salaries. Diabolical consistency must have dictated the policy of including among "extraordinary large expenditures for administration," Dr.

* Dr. Theobald Smith (1859-1934) began this study early in his career, under the auspices of the Bureau of Animal Industry in the Department of Agriculture. He was immediately put to work on a mysterious disease of cattle known by the name of Texas fever which was causing widespread devastation of stock in the southern states.

Porter's unchanged, annual salary of $3,000. It might be noted in passing that, in this final year of his tenure, the State Board of Health could take pride in an organization of six bureaus: Bureau of Communicable Diseases and its three divisions, Field Service, Diagnostic Laboratories, and Isolation Hospitals; Bureau of Education, in charge of publications, exhibits, and library; Bureau of Child Welfare which administered the program for crippled children and gave a head start to medical inspection of school children; and the Bureaus of Engineering, Vital Statistics, and Sanitary Science.

Dr. Porter, having reached the age of 70, had to yield to the immutable and inflexible state law of mandatory retirement. But this able fighter and soldier felt very much alive and had no thought of being put on the shelf. He applied for a commission to his old friend, Dr. William C. Gorgas, Surgeon General of the Army Medical Corps, who helped reinstate Dr. Porter to his former rank of colonel. He was first assigned to Fort Jackson, South Carolina, and then transferred to Camp Johnston in Jacksonville where he spent the remaining years of the war. In 1919 he returned to his home in Key West, where for a number of years he served without remuneration as city health officer, district health officer and president of the Chamber of Commerce.

Now he was fast approaching the age when disturbing thoughts of having to give up these engrossing civic activities troubled him. In the winter of 1922 he suffered the loss of his third child and youngest daughter, Roberta, who died at age 48.

Despite this sad interlude, Dr. Porter continued bravely to maintain an active interest in civic affairs and the medical profession over the five remaining years of his life. All his writings showed that he was still a keen judge of people and a shrewd philosopher who sensed their problems. Aside from his outstanding contributions to the literature on yellow fever and communicable disease control, perhaps the last series of publications in 1925 and 1926 crowned his unprecedented career. "Looking Backward Over Fifty Years of Health Work in Florida" is a chronicle of the health history of the state, narrated simply and modestly from the experiences of its first health officer.

This final work, which spanned more than half a century in his career, is mute testimony of his humane nature. He met fear, ignorance, indifference, prejudice and harsh politics, gaining many victories in the manner of a born leader.

He was indeed a likable person who in turn liked people although he shunned the social whirl. His grandson, an eminent attorney at Key West, often told that when he was a young boy, he could never understand why Dr. Porter, his grandfather, married his grandmother who was so completely without humor and disliked being around people. On one occasion he mentioned to his father,* "grandfather must have married her for her money, for she had nothing else that he could marry her for." His father replied "that is not true at all, son, she played the piano beautifully."

Dr. Porter, the practitioner of medicine, was always known and respected as an exceptionally fine physician with outstanding diagnostic skill. In the waning years of his life, when infirm and almost totally blind, he never failed to respond to the call of his patients. At such times, Beulah, his wife, a former nurse, served as his eyes and from the patients' description of their ailments he made his diagnosis. Perhaps an overabundance of sympathy and empathy in his make-up is the most likely explanation of a close friend's comment: "He was a terrific hypochondriac; the only illness a patient ever had that he hadn't personally suffered from was pregnancy."



Fig. 3.—Dr. Joseph Y. Porter's Birthplace in Key West. The house was built in 1837. It became known as the Randolph House when Dr. Porter's grandparents, Captain Thomas Mann Randolph and Susan Randolph, first occupied it. In later years it was the home of Mary Ann Randolph, their daughter, before her marriage to Joseph Yates Porter in May, 1845. Dr. Porter was born in this house in 1847 and occupied the same room for 75 years except when duties called him away from Key West.

Photograph courtesy of Dr. Wilson T. Sowder, Director, Division of Health, State of Florida.

* Excerpt from an interview of Joseph Yates Porter (grandson of Dr. J. Y. Porter, the first State Health Officer) by Dr. William M. Straight at Key West, Florida, April 17, 1966.

The end came to this colorful figure in 1927 shortly before the age of 80 at Key West in the old Randolph-Porter home in the same room where he had been born (Fig. 3). It is pertinent to recall what he had written in regard to his own attack of yellow fever. It seemed to him then that his case might be of some interest to medical men for two reasons, "The amount of ignorant medication the human system can throw off, and the fact that no one dies until his or her predestined time arrives."

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▶ Dr. Eberson, 3262 C 67th Terrace South, St. Petersburg 33712.

Dr. Isaac Hulse, 1797-1856



Fig. 1.—Reproduced from Werner: Dr. Isaac Hulse, Life and Letters, by courtesy of Librarian, P. K. Yonge Library of Florida History, Gainesville, Florida.

Reared on his father's farm at Coram, Long Island, in Suffolk County, New York, where he was born Aug. 31, 1797, Isaac Hulse, the youngest son, found country life quite dull and without romantic appeal (Fig. 1). Whether or not he heard the call of the sea* at such an early age, he occupied himself more agreeably sailing miniature boats on the pond than by sharing farm chores with four older brothers. When one of them, enraged by this attitude, destroyed Isaac's entire fleet, young Hulse swore never to toil in the cornfield again.

Actually, both by heritage and background, career. His father, Major Caleb Mapes Hulse, descended from an old line of early pioneers, was commissioner of schools in 1798, town trustee for several years and president of that body in 1809. When he died a year later, his son Isaac, then 13, had already learned the value of a sound education and decided to leave the homestead for greener pastures. He studied to become a teacher in the common schools and after his first assignment in Westchester County, attended Union Hill Academy in Jamaica, Long Island, where he mastered Latin, French and Greek and then taught these languages.

After coming to Baltimore to accept a teaching position, he became deeply interested in the study of medicine and entered the University of Maryland in 1821, graduating with honors two years later. His medical thesis on the subject of yellow fever, composed and read in Latin, was awarded a gold medal.

Immediately after graduation, Dr. Hulse joined the Navy and within two weeks began his career as Surgeon's Mate and embarked on cruises that took him to the West Indies, Gibralter, and the West Coast of Africa where he made his first contact with yellow fever. Returning to Baltimore shortly afterward, he was directed to the Naval Hospital at Gosport, Virginia, where he served more than two years as Assistant Surgeon of the

* The Hulse farm was located about 12 miles south of the nearest point of Long Island Sound and 15 miles north of the Atlantic Ocean.

hospital. This position was much to his liking, as his correspondence at the time revealed a pronounced aversion to sea duty. During this period he regarded Baltimore, his wife's native city, as his home, and there he spent most of his free time.

Ordered to Pensacola

In the spring of 1825, Dr. Hulse was promoted to Surgeon in evidence of his ability and skill (Fig. 2). In mid-November 1826, he was ordered to the Naval Hospital at Pensacola, Florida, where his reputation as a distinguished medical man spread throughout the southern United States and the entire Navy. Especially noteworthy was his successful treatment of the dreaded yellow fever, the terrible scourge of those times.

Dr. Hulse's service coincided with the beginnings of Pensacola as a naval station, first established shortly after Florida became United States territory in 1821. From 1826, when Dr. Hulse came to the Naval Hospital there, until 1835, little concerning his life and accomplishments has come to light. During this period, letters, lost or destroyed, are entirely lacking.

The first hint that he was winning a battle with epidemic yellow fever was found in a letter written from the U. S. Naval Hospital, Pensacola, April 12, 1836. A recapitulation of the results of his practice for three years and four months showed that he lost only nine of 80 cases of yellow fever; of these, four came to his notice at an unfavorable stage of the disease.

Attesting to his remarkable skill in treating fevers, there is a letter from Pensacola dated Nov. 2, 1839, after an epidemic of malignant fever. His services were in such demand that he scarcely had time for ordinary rest and sleep. The Commodore of the fleet decided that the disease, beginning to spread among the officers and seamen on shipboard, made it advisable for the vessels to leave port "for the purpose of changing the atmosphere and removing the chances of mortality within his command." At the request of the people of Pensacola, Dr. Hulse was left behind to fight as best he could with inadequate supplies of medical aid. Up to the time of his writing, he had attended 140 cases of the fever and lost five. "I am now sick with cold and a slight pleuritic affection, but hope to be out tomorrow." (Incidentally, his "fees have amounted to $1,200 in a little upwards of six weeks.")

In September, 1837, Dr. Hulse was appointed Fleet Surgeon, attached to the West India Squadron, serving in that capacity until September, 1840. Following a leave of absence during the next six months, in April, 1841, he resumed his former position in charge of the hospital at Pensacola. To this port the squadron returned about every three or four months. With his close friend, the Commodore, in command, it appeared that Dr. Hulse's tour of duty with the squadron was most agreeable.

Toward the latter part of the year, yellow fever struck again in Pensacola. Dr. Hulse, corresponding with his lifelong friend, Mr. Benjamin F. Thompson, wrote on Nov. 30, 1841, about this visitation.

Since August 30 he had had under his charge 151 cases of yellow fever in addition to many other varieties of illness. The French Squadron in Pensacola did not escape, and after having treated on board their ships 14 cases of the disease, losing five, they began to compare the lack of success of the French surgeons with Dr. Hulse's and the French Commandant formally requested permission to send their sick to the Pensacola hospital under Dr. Hulse's charge. Eighteen cases were then sent there, of whom only two were lost. Of Dr. Hulse's 138 patients, in all, 11 died. It appeared he might have saved one or two more had not the patients been injured during transportation to the hospital, in some instances under unfavorable circumstances. His success was considered remarkable and his consummate skill brought a letter of commendation from the Secretary of the Navy—indeed unusual recognition for a surgeon to receive.

Dr. Hulse, always modest, writing to his dear friend, Mr. Thompson, "communicated this with some pride, because I know you have always expected much from me and I believe have esti-



Fig. 2.—Birthplace of Dr. Isaac Hulse, Coram, Long Island, N. Y.

Reproduced by courtesy of Librarian, P. K. Yonge Library of Florida History, Gainesville.

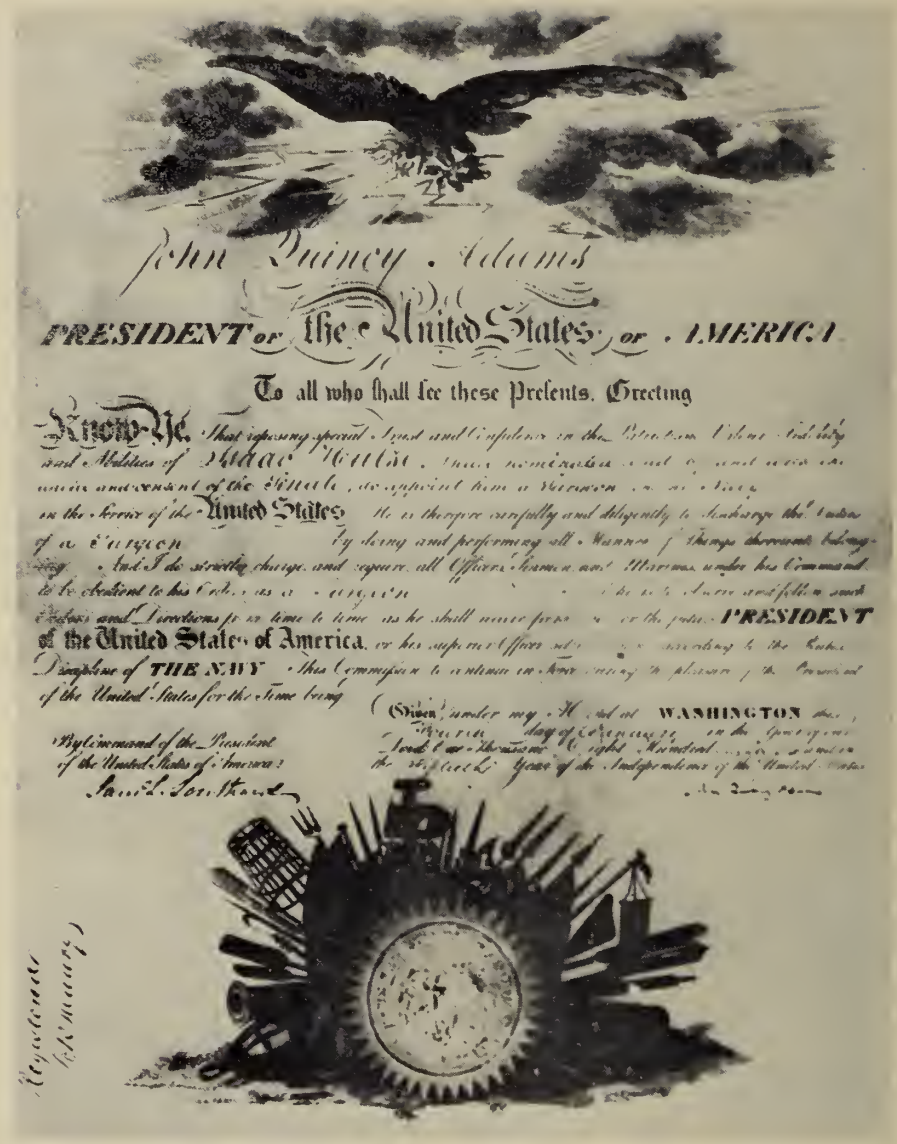


Fig. 3.—Dr. Hulse's commission as a Surgeon in the United States Navy issued by President John Quincy Adams.

mated my qualities more highly than they deserve. . . . If, on this occasion my professional reputation has acquired something, I feel it is for such men as yourself that I have earned it."

Monograph on Yellow Fever

In an outstanding contribution, "Monograph on the Yellow Fever," published April, 1842, Dr. Hulse gave a vivid description of the disease.[1] He attempted to trace its remote and proximate causes and to present a successful method of treatment suitable in all its phases.

He considered yellow fever a disease of hot climates and alluvial soil, epidemic in lowlands and marshes of tropical America and in some of the southern states, particularly at the mouth of rivers. In these localities it was not usually epidemic unless preceded by an exceptionally hot and dry summer. So far as he could understand, the disease did not occur during seasons of abundant rains. Most writers, he noted, inferred that it originated in "those effluvia from dead animals and vegetable matter, and these inferences appear to be well supported."

He wrote that, despite an unusually hot and prolonged dry season lasting through September, hope for immunity from yellow fever at Pensacola was not realized, although abundant rains fell during the early part of the summer. Never before had the disease been known to appear during a wet season, yet not until the latter part of September "some cases, chiefly among persons not acclimated" appeared in the city. At nearby Mobile, however, where prevailing conditions usually favored an outbreak, yellow fever did not occur in epidemic form. He explained this by assuming that the abundant rains of early summer caused swollen rivers in the delta opposite Mobile, which kept the marshes well supplied with water. Further, he added, the course of these rivers was so long that their sources were not exhausted before the timely October rains.

To what extent, if any, Dr. Hulse concurred in the traditional beliefs of "noxious effluvia and miasmata" can best be surmised from his analytic treatment of the whole subject. Pursuing his investigation, he adduced "numerous facts to prove the existence of a cause additional to that in the atmosphere, in the foul state of the hold of the ship, the Levant, a sloop of war," which lay opposite Pensacola during the month of August. On the last day of that month, four cases of yellow fever on shipboard were admitted to the hospital. After three or four days, the ship was dismantled in the Navy Yard and the crew sent on shore, while a number of the men still communicated with the vessel. By the end of September, 99 more cases of yellow fever among her officers and crew had been admitted to the hospital. From the ship's company, now located at the Navy Yard, 39 new cases, which developed afterward, were admitted, making a total of 138 from that single ship. Not until early in November, after several severe frosts, did yellow fever disappear. During this entire period, only one or two adequately confirmed cases could be traced to the Navy Yard among all the officers, seamen, marines, mechanics and laborers stationed there. Pointedly, Dr. Hulse reported that not one case of yellow fever developed among the officers and attendants of the hospital, located on a bluff, one mile from the Navy Yard and a mile and a half from the Gulf of Mexico.

Complementing this study, Dr. Hulse cited his findings on two French war vessels. There were 14 cases of yellow fever on board with five deaths prior to docking at Pensacola late in September, when these patients were first being admitted to the Navy Yard hospital. After arrival of the vessels, 18 new cases developed but only two died. By October 7 there were no more cases of yellow fever, all the convalescents were put aboard on the 12th and the ships sailed a few days later for Havana. From these observations Dr. Hulse concluded that "the disappearance of the disease must be attributed to a change of location to a healthy atmosphere." In contrast, the Levant had 21 new cases of yellow fever after the disease has disappeared from the French vessels.

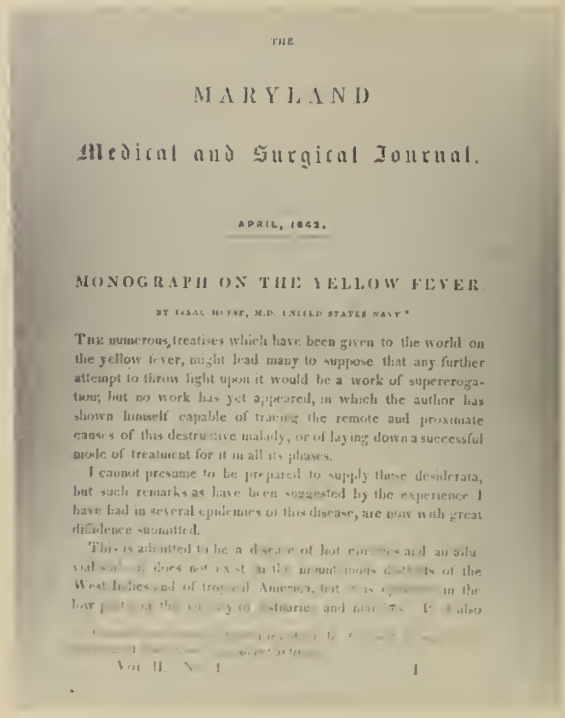
Although he reported variations in morbidity coinciding with removal of patients and contacts from shipboard to the hospital, Dr. Hulse made no pointed reference to current theories of quarantine or contagion and their relation to the "noxious effluvia" responsible for the spread of yellow fever.

Whether or not he was familiar with the works of his early predecessors or contemporaries has not been revealed in Dr. Hulse's "Monograph on the Yellow Fever." In the opening paragraph he wrote that he hesitated to assert himself on the subject of yellow fever because any further attempt to throw light on it would be superfluous. . . . "but no work has yet appeared, in which the author has shown himself capable of tracing the remote and proximate causes of this destructive malady, or of laying down a successful mode of treatment for it in all its phases." In this connection, there are several major contributions worthy of mention.

Several Major Contributions

Dr. Charles Caldwell, in 1795, noted "regular abundance of *muskitos* whenever and wherever epidemic yellow fever prevailed."[2] In a later publication he suggested not only the probable role of noxious insects, *"muskitos,"* in spreading an epidemic but also observed the "injurious effect of frost on their survival."[3] About the same time Dr. Samuel Brown called attention to the "noxious effluvia, a vapor or stream of invisible, infectious particles generated by filth and decaying matter" as the source of pestilential fevers.[4] In another respect, his concept of contagion went beyond that of Dr. Caldwell. Concerning the transmissibility of yellow fever in Philadelphia and elsewhere since 1793, Dr. Brown found the mortality greater among physicians, nurses and other attendants on the sick than among other inhabitants.

In 1842, Dr. John Wesley Monette published



THE

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Medical and Surgical Journal.

APRIL, 1842.

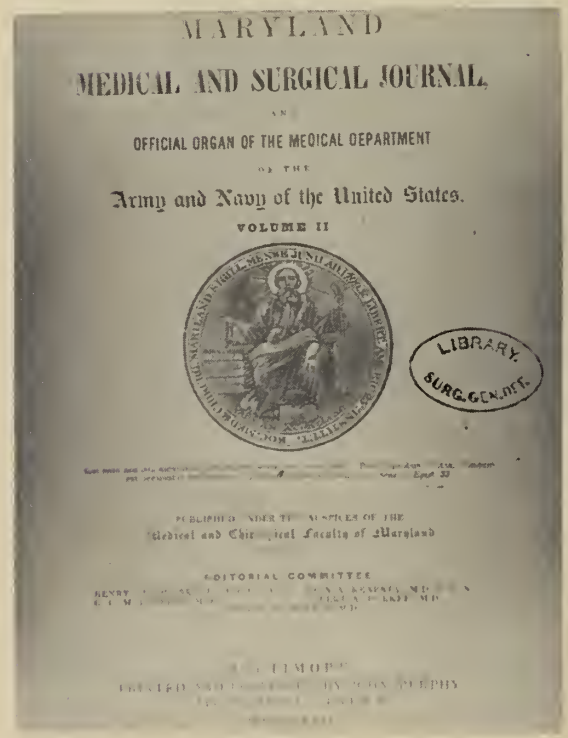
MONOGRAPH ON THE YELLOW FEVER.

BY ISAAC HULSE, M.D. UNITED STATES NAVY.

THE numerous treatises which have been given to the world on the yellow fever, might lead many to suppose that any further attempt to throw light upon it would be a work of supererogation; but no work has yet appeared, in which the author has shown himself capable of tracing the remote and proximate causes of this destructive malady, or of laying down a successful mode of treatment for it in all its phases.

I cannot presume to be prepared to supply these desiderata, but such remarks as have been suggested by the experience I have had in several epidemics of this disease, are now with great diffidence submitted.

Figure 4



MARYLAND

MEDICAL AND SURGICAL JOURNAL,

OFFICIAL ORGAN OF THE MEDICAL DEPARTMENT

OF THE

Army and Navy of the United States.

VOLUME II

LIBRARY SURG. GEN'L'S OFF.

Figure 5

Figures 4 and 5 were prepared for the author by The National Library of Medicine.

a classic work based on his experience with epidemic yellow fever in which he discussed the controversial problems regarding its origin, spread, and method of control.[5] A vigorous crusader for quarantine, he was, over a period of 15 years, almost alone among the medical profession in the southwest with the courage to declare publicly in favor of a strict quarantine to prevent the importation of yellow fever. He recommended regulations to protect all commercial ports and populations exposed to the disease. In addition, he felt an indispensable need for strategically placed hospitals for the sick from detained vessels. Further, introduction of unacclimated persons to infected localities must be prohibited and "all strangers, or those not acclimated by a residence of two to three years were to be evacuated from the city."

Fully six decades would pass before some of these debatable issues were settled; yet as late as 1892 the ghost of contagion in yellow fever had not yet been laid. Writing on this subject, Dr. Osler stated, "The epidemics (of yellow fever) are invariably due to the introduction of the poison either by patients affected with the disease, or through infected articles. Unquestionably the poison may be conveyed by *fomites*."[6]

With regard to the treatment of yellow fever, however, Dr. Hulse struck out boldly. His philosophy of therapeutic management was diametrically opposed to the idea of indiscriminate bleeding and purging, and therein lay his remarkable success. Instead, he practiced cautious venesection early in the disease, combined with mild catharsis, and only when the patient's circulatory condition and vitality warranted these procedures. Overdosage with mercurials and the like, he avoided at all times. This commonsense method, totally unlike that of the celebrated Dr. Benjamin Rush, proved most successful in his hands to a degree never before achieved. During the historic yellow fever epidemic in the North, Dr. Rush was known to take 144 ounces of blood at 12 bleedings in six days and as many as four in 24 hours. Within the course of these six days, he gave nearly 150 grains of calomel, with some jalap and gamboge (also effective purgatives) for good measure.[7]

Treatment, in Dr. Hulse's view, depended for the most part on clinical symptoms which varied in some epidemics. Under conditions of lowered vitality with attending sluggish circulation, he withheld venesection which he considered injurious and more often than not, fatal. As proof he cited the yellow fever epidemic at Pensacola in 1839

when, in his private practice, he treated 146 cases almost invariably without bloodletting, losing only six patients. The disease usually ran its course in four to five days without fever remission, but under proper treatment many cases were terminated favorably in 24 to 48 hours with rapid convalescence.

Persistent bloodletting, he continued, ought never be attempted when circulatory weakness occurs, as it often does, with purgation. In patients showing a strong vascular response after the first 24 hours, venesection was rarely needed, and, in his opinion, should never be practiced after the first 48 hours since it was "never his good fortune to see a patient recover, who was bled on the third day."

Proposal of Preventive Measures

Toward the end of the year when this article was published, Dr. Hulse, in a letter to Thompson, wrote, in part, that he was still at the Pensacola hospital and his labors greatly augmented since the establishment of a Medical Bureau at Washington. He was now completely in charge without supervision of the Commissariat of the Station. All the correspondence of the Bureau, the Commissariat of the establishment and government odds and ends devolved on him.

Late in October, 1844, Dr. Hulse acknowledged a letter from Thompson, his "very dear and ancient friend," while on a sick bed to which he had been confined for some time. There is reference to another type of fever to be distinguished from the genuine yellow fever. From his account it appears that this was malaria. The disease which afflicted Dr. Hulse as well as every member of his family "is a new one in this part of the world and is the same as that which was met with in South Florida by the Army Surgeons."

This fever, appropriately named "Malignant Intermittent" was characterized by extreme prostration in a very short time and frequent relapses confining some persons for three months. Nearly all the inmates of the hospital were afflicted but none died. Dr. Hulse himself had become much emaciated and debilitated and the meninges of his brain involved. It is interesting to read that *"the last two or three nights we have had frost and it is presumed the malaria which gave origin to the disease is extinct"* (italics mine).

Though frequently stricken with the fevers which sapped his vitality over years of exhausting labor, the fortitude and philosophy of the man was revealed in his contemplation of life. He was only 47 years old when he wrote, "whether all these sufferings he is called to experience are or are not calculated to shorten the period of existence allotted to me, I know not, neither does the contemplation of the subject give me so much concern as it did in former years—death becomes less and less formidable the more nearly it approaches."

Notwithstanding the frequent gaps in Dr. Hulse's correspondence, it appeared that, for the remaining years of his life, he pursued and was pursued by the epidemic fevers.

Writing from the U. S. Naval Hospital in Pensacola early in 1847, he reported an epidemic at the hospital and in the vicinity of the Navy Yard originating in "local causes." There were "ten to twelve deaths, including some distinguished persons." Scarcely anyone living at the hospital escaped an attack, many inmates having from one to four attacks, and the epidemic ended with the appearance of frost.

In connection with this epidemic it is noteworthy that Dr. Hulse for the first time regarded the solution of the problem from the standpoint of improved sanitation and application of preventive measures. Having experienced an outbreak the year before associated with similar unfavorable environmental conditions, he proposed that a Joint Commission of Army and Navy Surgeons study the disease and suggest possible methods of preventing its reappearance.

Accordingly, early in November, 1844, a board of Army and Navy Surgeons consisting of six medical officers with Dr. Hulse as President made a report and recommendations. This resulted in an appropriation of $7,000 for complete drainage of all ponds and elimination of any possible accumulation of stagnant water in the area.

This letter also contains a reference to a son, John Isaac, not previously mentioned, who was "asking for a Lieutenancy in one of the ten regiments of the army. He has served with credit at Point Isabel (a) when that place was menaced prior to the Battles of the 8th and 9th of May." (b) John Isaac Hulse, it appears, was graduated in March, 1859, from Jefferson Medical College. His thesis on the subject of yellow fever seemed to follow in the footsteps of his father who did not live to see it (c).

In reply to what must have been an inquiry, he concluded the letter with a report on the progress of the Hospital Library which he was establishing. At Dr. Hulse's suggestion, "the Secretary of the Navy consented to his opening a subscrip-

tion among the invalids and permitted him to beg from distinguished publishers, booksellers and learned associations." Donations from all over the United States had already swelled the total number of volumes to 400 and the Secretary of the Navy promised to put $150 at his disposal. Dr. Hulse, incidentally, added to the Library a copy of Thompson's "History of Long Island."

a) A point near the present boundary of Texas and Mexico, on the Gulf.
b) Now known as the battle of Resaca de la Palma, one of the early engagements of the Mexican War.
c) The writer is indebted to Dr. William M. Straight for the reference concerning the list of graduating physicians at the Jefferson Medical College. Commencement of March, 1859. It appeared in the American Journal of Medical Sciences, n.s., 37: 585, April, 1859. The National Library of Medicine verified Dr. John I. Hulse's graduation date, but not the listing of theses in this volume.

When the intimate correspondence ended with the death of his lifelong friend and confidant, Mr. Thompson, much of Dr. Hulse's life became a closed book. His last letter of February, 1849, about a month before Mr. Thompson died, aged 64, was written in the month during which Dr. Hulse was away on a 30 day leave of absence.

Two years later, he was assigned to duty on the U.S.S. Saranac, and then appointed as Fleet Surgeon of the Home Squadron. This was considered a highly important position, offered only to surgeons of repute and experience.

In June, 1852, Dr. Hulse was ordered to return to Pensacola, apparently to help fight another outbreak of (yellow?) fever. There was no choice left, but to ask him who had no peer in the treatment of this disease.

The naval records show that Dr. Hulse held this hospital assignment until Aug. 29, 1856, when he died just two months short of his 59th birthday anniversary.[8] . . . Home came the warrior to the scene of his first triumphs, and now a last victory over the arch enemies—Disease and Death.

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The United States Marine Hospital
Key West, 1845-1943

Alvan G. Foraker, M.D.

The U.S. Marine Hospital in Key West played a vital part in meeting the health needs of the community for almost 100 years. Because of the geographical isolation of Key West, this hospital fulfilled a far larger role than did other Marine hospitals located in more centrally situated and cosmopolitan communities.

The concept of governmental responsibility for medical care of seamen dates back at least to 1588, when after victory over the Spanish Armada, Britain opened a hospital for seamen of the Royal Navy.[1] The American colonies' interest in the welfare of seamen led to the establishment, in 1708, of a hospital for seamen at the fort at Point Comfort near Norfolk, Virginia.[2] Boston and New York also made efforts to provide for the medical care of seamen. A major step came in 1798 when President John Adams signed into law a bill passed by Congress directing the master of every United States' ship to pay to the Collector of Customs a sum equal to 20 cents per month per crew member, to be deducted from wages.[1] Hospitals were to be erected and operated in the principal ports. This was the United States' first prepaid system of medical care.[2] Over the years, the number of hospitals in principal ports gradually increased and the service expanded.

In general, the principal beneficiaries of the Marine Hospital Service have been American and foreign seamen, officers and enlisted men of the U.S. Coast Guard and their dependents, certain categories of other military and federal personnel and special groups as provided by Congress. In recent years, several of the U.S. Public Health Service (formerly Marine) hospitals have been closed[1] and the remainder are scheduled for closing in the near future.[3]

Early Key West

Permanent settlers arrived in Key West near the end of the 18th century.[4] The "proximity of the island to Havana, nerve center of the Spanish Caribbean, and location of the much traveled Florida Straits, marked it as a logical point of entry."[5] In 1822, the United States Navy occupied the island and used it as the headquarters of a "task force ordered to rid the Caribbean Sea of pirates known as the 'Brethren of the Coast.' "[4] Hospital quarters which were erected were the first housing facilities ever provided in Key West by the U.S. Government for the care of sick seamen. Dr. Thomas Williamson, the hospital surgeon, served from April until October, 1823.[4] In 1831, Dr. Benjamin Strobel was the Surgeon of the Army Post[4] and also Editor of the Key West Gazette.[5] Another physician of the time was Dr. Henry S. Waterhouse, who advocated various sanitary precautions for the community.[5] The local medical problems were aggravated by the considerable number of indigent sick. A grossly inadequate Marine hospital fund provided small sums, such as $3 per week for board, lodging, and nursing, and 25 cents per day for medical services.

In 1835, Mr. William A. Whitehead, a prominent citizen and official, made the following comment:

"Situated as Key West is, it is calculated at all times to become a receptacle for the sick of vessels leaving the ports of West Florida, Alabama and Louisiana, and also those bound to the Northward from the Coast of Mexico, as there is no port offering equal advantages as a stopping place, and none between Charleston and Pensacola possessing the superior attraction of a hospital. Such being the case, seamen are brought here sick to be left to the care of strangers, dependent on private charity (there being no municipal regulations for their support) and the hospital fund of the United States for their nursing and subsistence. We would therefore recommend the application for the establishment here of some public accommodations for the sick seaman, whereby his comfort may be in some measure secure while incapacitated by disease—to which they are liable —from pursuing his usual vocation."[6]

From 1835 on, the people of Key West, through their representatives, urged Congress to establish a Marine hospital in the city.[6] In 1844, a site was selected on the waterfront of the harbor, outside the corporate limits. This site was

chosen since sick could be carried to the hospital without passing through the town. Later in 1844 the construction of the building was begun. It was two stories high, measured 100′ x 45′ and was equipped with 60 beds.[7] A wharf was constructed on the west side to enable small boats to come alongside and discharge their sick without risk to the townspeople. The hospital opened for use Aug. 2, 1845 (Fig. 1).

The Hospital (1845-1918)

Yellow fever prevailed as an epidemic during at least 15 summers between 1857 and 1884.[4] In 1863, Dr. David T. Lewis was appointed Surgeon of the Marine Hospital and died a few weeks later of yellow fever after an 11 day illness. The epidemic of 1899 was the worst in the history of the island, when 1,320 persons had the disease and 68 died. Assistant Surgeon W. R. Adams of the Marine Hospital, who was in active charge of the yellow fever patients, died himself after a six day illness.[8]

Smallpox was also recurrent, with an epidemic in 1872, and significant presence of the disease in 1896.[4]

During the Civil War, Key West and its hospital remained in federal control. Like other Marine hospitals, it was used for general medical military purposes.[1]

The Key West Marine Hospital suffered from recurrent damage and problems with its plant. In 1873,[8] the Supervising Surgeon General of the Marine Hospital Service reported, "Key West, Florida: The buildings and grounds have suffered serious injury from storms several times since the hurricane of 1846. The service has always been small, and the hospital one of the most expensive to maintain, in consequence of its isolated position on an island."

During the Spanish American War (1898) many sick and injured seamen were housed in the Marine Hospital.[4] Most Army personnel went to the Army hospital in the Convent of Mary Immaculate which had been offered, gratis, by the Mother Superior.

In World War I, the hospital was heavily involved in the epidemic of influenza in 1918. An additional physician and two nurses were sent to help cope with the epidemic.

Between the World Wars

Key West deteriorated economically after World War I. Major cigar factories had moved to Tampa in 1886.[9] Cuban trade declined after the armistice and steamship lines dropped Key West as a port of call. Gradually, Army, Navy and Coast Guard closed their Key West bases. Sponging had been a major industry, but local



Fig. 1.—View of U.S. Marine Hospital and beach. Exact date not known, but prior to World War I when docks were constructed in front of the hospital. National Archives Photograph 90-G-17D-5.

spongers could not withstand competition from the more efficient Greeks, based at Tarpon Springs. The Overseas Railroad from Miami, completed in 1912, was destroyed in the hurricane of 1935. Many of the injured from this hurricane were treated in the Marine Hospital.[10]

The depression of 1929 hit Key West hard. In 1934, 80% of the working population was on relief, and the city was bankrupt.[9]

Key West was not self-sufficient medically, as far as furnishing hospital care, especially to the poor. From time to time, doctors had maintained small "cottage" type hospitals. The Mercedes Hospital was largely custodial.[11] "The city was caught with no facilities to give proper medical aid to the poor. Even so it was apparent that local physicians were largely responsible in blocking several attempts by the Federal Government, the Commonwealth Fund and the Rockefeller Foundation to endow a municipal hospital. They and the citizens could not agree as to the management of such an institution, because the local practitioners were without the qualifications to staff such a hospital. The result ended with the Public Health Service taking the brunt of the responsibility for all medical care requiring hospitalization. Those who could afford it frequently went to Miami, Havana or other large cities for consultation. After the depression, the hospital frequently ran in the 'red' financially. Compared with the standard allowance of $3.75 per patient-day by the U.S. Treasury this institution would often have to ask a fee of five to seven dollars a day to break even. This remained true to the day the clinic closed its doors. Desperate circumstances in Monroe County led to an agreement whereby a special rate of $2.00 per case was made for cases from the Community Clinic. This arrangement was never discontinued after the depression. Although the Good Samaritan deeds were supreme in importance to the vicinity, most of the civilians remained unwilling to try and help defray expenses incurred by them."[4]

During these difficult times, physicians and employees of the Marine Hospital worked closely together to give good medical and hospital care to conventional Public Health Service beneficiaries and to people of the community.[12] "In 1930, the Marine Hospital was one of 24 institutions accredited by the American College of Surgeons for interneships."[4]

Care for veterans of the Spanish-American War and World War I was authorized in 1928. This service was fully utilized by professional veterans, especially during cold winters up North.[13] During these months, the wards and corridors were jammed with beds to accommodate this incursion. In the fall, numerous veterans arrived by train from Miami. After riding in stretchers via ambulance from the train station, the men promptly applied for passes. These enabled them to go uptown and begin their winter of serious drinking. Other service beneficiaries, including merchant seamen, were also much more numerous during the winter.[14]

Ernest Hemingway was familiar with the Marine Hospital, having been treated there for a gunshot wound of the foot.[15] The hero of Hemingway's novel "To Have and Have Not" made a precarious living by illegal operations with his boat between Key West and Cuba.[16] He was shot in a fight with bank robbers out in the Gulf. The Coast Guard brought him to the Marine Hospital, where he died on the operating table while his wife and two daughters sat outside in the hall.

Personal Recollections

In July 1940, I arrived for duty, fresh from an internship in Pittsburgh. Key West seemed tropical, somnolent, shabby and badly in need of several coats of paint. The hospital also looked tropical, white, surrounded by palm trees and attractive grounds. My quarters were a small bungalow, behind palmettos and poinsettias, said to have been formerly the morgue.

Dr. Anthony P. Rubino, the Medical Officer in Charge, was a surgeon and a Fellow of the American College of Surgeons. The only other medical staff member was Dr. Paul D. Holloway, who was in charge of medicine, the venereal disease ward and the x-ray service. These fine physicians were the essence of kindliness, ability and concern for their patients. The remaining staff—nurses, attendants, clerks, cooks—were pleasant, cooperative and capable.

I functioned as ward medical officer, assistant at major surgery, minor surgeon, part time anesthetist, tonsillectomist, pediatrician, obstetrician, and outpatient physician, plus such odd jobs as participation in immigration and quarantine inspection. It was a broadening experience.

The hospital had about 80 beds. Our patients included merchant seamen, veterans, Army, Navy, Marine and Coast Guard personnel and their dependents, and government employees with service-related injuries and illnesses. These were all conventional Public Health Service beneficiaries. Peculiar to Key West was the presence of non-

service beneficiaries from the community. Some of these were indigent. Nonindigent civilians were also admitted, especially in emergencies, including tourists from the North, who became suddenly ill and were distressed to find themselves in the Marine Hospital ward minus their appendices. The hospital was reimbursed for services to these people by the Key West Community Clinic, as noted.

The town then had a population of 12,000 and four active practicing physicians. Two of these were elderly and not in good health. A third operated a small "cottage" type hospital behind his office. One physician then in practice, Dr. Julio J. DePoo, is still professionally active. The Marine Hospital was the only functioning hospital in Key West or the Florida Keys with full medical and surgical facilities, laboratory, x-ray and American College of Surgeons' approval. We had the only emergency room. The physicians of the community relied on the hospital medical staff for consultations, as well as for inpatient care of their patients.[17]

At this time, there was some economic revival, due largely to increasing military activities in the pre-World War II era. The Navy expanded facilities and personnel. The Naval Dispensary reopened in 1939 and had bed care facilities for minor illness.[4] However, all major sickness, surgery, and inpatient care of dependents required the use of the Marine Hospital.

Some of my most critical problems involved obstetrics. On the basis of six weeks obstetrics-gynecology service during rotating internship, I found myself the southernmost obstetrician in the United States. My most critical case involved an unmarried Cuban girl admitted after several days labor with a severe cephalopelvic disproportion. She had been in the hands of midwives and had a purulent staphylococcic discharge. Heavy doses of sulfathiazole, a new drug of the day, were instituted.[18] Dr. Rubino could have performed a classical caesarean section but infection prevented. I borrowed a cranioclast from Dr. J. Yates Porter Jr., son of Florida's first health officer. When the fetal heart sounds ceased, I performed a craniocleisis, an operation I had seen once as a medical student. The patient recovered uneventfully; the episiotomy was repaired. Several weeks later, I saw this girl on the street with some sailors.

Because of the shortage of civilian physicians, it was generally understood that the hospital medical staff could engage in private practice on outpatients. Drs. Rubino, Holloway, and I were extremely unaggressive in this regard, making no charge to the great majority of our civilian emergency and outpatient clients. One of my predecessors as junior medical officer was more enterprising. He had been treating young Navy flyers surreptitiously for their venereal diseases, so that their service records remained unsullied. This was a trifle hot for a timid soul like myself. More or less as a public service, I did continue a little syphilis clinic for civilians, charging a dollar a shot, plus the wholesale cost of the Mapharsen. A local pharmacist threatened to report me to Washington unless I bought the Mapharsen from him at a high mark-up retail price, so I promptly closed the civilian syphilis practice.

A varied clientele patronized our emergency room. Our raffish customers swore, fought, drank, fornicated, jumped off piers, stabbed and shot each other and themselves, while generally engaging in a rich full life. Key West natives (known as "conchs"), tourists and service personnel brought their problems to us. In addition, there was a goodly number of Bohemian types, some of whom seemed to be "remittance men" in the style of Somerset Maugham. Their relatives gave them stipends to stay away from Dubuque and not disgrace the old family name. Key West was the natural habitat of such people.

We also catered to professional and semiprofessional prostitutes. Some were "sea gulls," the girls who follow the fleet. One rather weather-beaten creature was admitted for alleviation of her pelvic inflammatory disease. Apparently she was being maintained by a consortium of young sailors, who could not afford a whole girl apiece. The ladies of the evening were given to suicidal attempts, frequently with Lysol. Some of these were serious attempts. On other occasions a girl would rub a little Lysol around her lips and start to scream, hoping to arouse sympathy or concern from her pimp or her colleagues. The State of Florida, of course, had laws against prostitution but these did not seem to extend to Key West, where the oldest profession was booming. There was a local rule that each prostitute had to be inspected by a physician at intervals. One girl said that she had been paying Dr. X, a respected member of the establishment, $5 every two weeks for several years for this inspection, but he had never lifted her dress tail yet. In gratitude for my care of her employees, one madame offered to send me several girls a week for this examination, thus increasing my modest income considerably. This also seemed rather hot, and I declined

the honor.

Duty Sundays, I passed the time suturing, extracting sea urchin spines from feet and removing fish hooks from various portions of our patients' bodies. One eventful Sunday, I plucked an automobile door handle from a large lady's gluteal fat. She had been fishing from one of the narrow wooden bridges on the Overseas Highway, with her rear protruding into the stream of traffic, when a car came by. The operation was a success.

Increasing military activity, plus a developing tourist trade, put more pressure on the Marine Hospital which had to cope with all these people —service personnel, their dependents, construction workers, tourists and civilians generally. Fortunately the Navy sent in a surgeon and an obstetrician, who were of great assistance. Dr. R. L. Pearse, the obstetrician, has related his experiences.[19]

In the midst of all this bustle occurred the events of Dec. 7, 1941. In January 1942, I left Key West for sea duty with the Coast Guard and Navy in the North Atlantic and Greenland.

The entrance of the United States into World War II greatly increased the work and responsibilities of the U.S. Marine Hospital in Key West. Even more service personnel and their dependents required treatment. The obstetrical service especially increased. The Navy assigned additional obstetricians. Dr. A. P. Rubino was transferred,[20] being replaced by Dr. T. H. Rose, the last Medical Officer in Charge of the hospital.[21]

German submarine attacks on tankers and other vessels in the Gulf, Florida Straits, and the Atlantic brought many injured merchant seamen, some in critical state, to the Marine Hospital. Doctors and staff worked night and day.[13] The Navy took over additional land around the Marine Hospital, making access to civilians more difficult.[14] The grounds of the Marine Hospital "were transferred officially to the Navy Department on November 21, 1942 with the understanding that the Public Health Service would continue to admit patients until December 21, 1942 and close January 1, 1943. Before and after the transaction, the townsmen of Key West petitioned responsible authorities in Washington, D. C., to keep the service going under the control of the U.S. Public Health Service, or guarantee that adequate hospitalization be provided elsewhere for the citizens. Even the Maritime Union opposed the closure on the basis that their members would have no other hospital available for a distance of several hundred miles radius."[4]

Navy and Army hospitals were completed in Key West in 1942.[4] The Marine Hospital closed its doors to the admission of patients on Feb. 14, 1943. The building was remodeled in preparation for the housing of WAVES (Women Accepted for Volunteer Emergency Service). At present, the building is being used for quarters for Navy officers and their families. It seems probable that the hospital building may be declared a historic site by the State of Florida and the federal government.[22]

The definitive article on the history of the U.S. Marine Hospital was prepared by Dr. Albert W. Diddle, an obstetrician stationed in Key West with the Navy at the time of the hospital's closing.[4] He wrote, "It can be said without reservation that this institution probably netted the city of Key West more humanness than any other establishment within its limits. The type of work performed will represent a goal for others to exceed."

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Reminiscences of Navy Medicine
Key West, 1941-1943

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After I finished my surgical internship, I signed on the U.S.S. Nantucket as surgeon. She was a Sloop of War built in 1874 and converted into the State of Massachusetts' Nautical School. The summer of 1934 I spent five months touring Europe in the beautiful square-rigger. The captain was a retired regular Navy officer and thus stimulated, I signed up for the Naval Reserve. This meant that I took some of the dullest correspondence courses ever conceived.

The call to active duty came and on March 28, 1941; my pregnant wife and I reported to the Commandant of the Naval Operating Base, Key West. The place was a riot of color, bougainvillea and poinciana were blooming everywhere. We were delighted to arrive after the long drive from Miami over the causeway that still showed the residual damage of the 1939 hurricane.

The promise that the Navy would continue me in my speciality and my recent board qualification gave me much assurance. My dismay was considerable after I reported to the medical officer, a regular with no children. I don't believe he clearly distinguished between a gynecologist and a pediatrician. He obviously regarded care of dependents as an annoying development. He had no concept of how pregnant women should be handled. The medical facilities at the Naval Operating Base consisted of only a dispensary. Dr. Corydon Wassell,* a former medical missionary in China, had been delivering the naval dependents unfortunate enough to be marooned in Key West. He was a wonderful old gentleman with a mycotic infection of his hands. Normal deliveries were carried out in a perfectly filthy room in a civilian hospital. Facilities were meager, no anesthesia, no personnel except an elderly practical nurse, and no means of blood transfusion. Only if the mother required surgery would Dr. Anthony Peter Rubino, superintendent of the Marine Hospital, permit her to be admitted to the only hospital in town, the antique thick-walled Marine Hospital. The old yellow building stood on the waterfront adjacent to the Navy Base. The Navy doctors treated medical disorders at the dispensary. The Navy had no facilities for major surgery and if the Navy personnel required major surgery, the doctors operated at the Marine Hospital, then later transferred them to the dispensary. The doctors at the Marine Hospital were pleasant and cooperative but adamant on admitting no normal obstetrical cases.

The first two weeks I was there I had two hair-raising experiences. I did two Water's extraperitoneal sections at the Marine Hospital, one for primary uterine inertia, the other for obstructed labor due to a posterior face presentation.

Olive Strauss was a dear person who wanted to stay with her husband, a submarine officer at the Sound School. She had been followed in labor for hours by a civilian practitioner and he had been attempting to flex the head. The uterus was paper thin and after delivering a daughter, she had a tremendous hemorrhage due to atony. Dr. Paul D. Holloway of the Public Health Service grabbed a number of passing blue jackets for donors and transfused Olive while I closed. In the welter of blood, I must have hooked the bladder with a stitch. She subsequently developed a vesicouterine fistula. This was later repaired and she had another child by section. Both the mother and babies did well. Olive and her family visited me when I became a civilian.

These experiences were somewhat unnerving. I continued to expostulate with the medical officer to educate him to the fact that all deliveries should be carried out in the hospital. Facilities for prompt surgery and blood transfusion just had to be available.

I was put on call day and night for dependents and not given a regular watch at the dispensary. The first thing I tried to do was to persuade all women expecting babies to leave Key West and sent my own pregnant wife back to

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*Later achieved national fame for the heroic evacuation of naval personnel from Java. See: Hilton, James: The Story of Dr. Wassell, Boston, Little, Brown & Co., 1943.

Durham, North Carolina.* The Dependents' Clinic was appalling to me. I had to do pediatrics. Dr. Wilbur Davison sent me the "Complete Pediatrician" and that saved me. I had to do social work, such as sobering up some visiting wife and arranging for the chaplain to find funds to send her home. Then I had to attend all the retired naval personnel and their wives. Everybody was very demanding and wanted house calls for everything from a baby with fever to sunburn. Very little time was devoted to my specialty. Some women were absolutely stranded in Key West because of financial reasons or lack of family ties, and I just had to make the best of the situation and deliver them.

One morning a young submarine officer's wife stepped into my office just after she had arrived in Key West by car. As I rose, she fell on the floor and became pale and pulseless. She had a ruptured ectopic pregnancy. I had no trouble admitting her to the Marine Hospital. The surgical nurse, Miss Hall, there was pleasant, emphathic and well-trained.

Light on the Horizon

Then a light on the horizon. The Navy sent a nurse, a splendid old regular, Miss Edith Stauffer, to Key West and she was assigned to the Dependents' Clinic. She was a tower of strength and helped me organize the clinic and discipline the patients. The unreasonable house calls diminished. Because of the squalor of the private clinic, I decided that home deliveries were in order. I had done them in the slums of Boston as a student and Miss Stauffer and I did a number. I continued to bombard both the Navy and the Public Health Service to permit me to do deliveries in the hospital.

A new chief medical officer, Captain Robert Team, arrived. He was a brilliant, pleasant, old China hand, very interested in ophthalmology. He had a wonderful family and I shall always feel great affection and admiration for him. He taught me how to get things done in the Navy. In no time a collaboration was arranged and I was permitted to do deliveries in the Marine Hospital. We used the operating table for deliveries. I did encounter some passive resistance. All nurses were not of the caliber of the surgical supervisor and some would not let me know when the mother arrived at the Marine Hospital. To my embarrassment and dismay, one mother precipitated her first baby as I walked in to make rounds. The nurse had put her in a bed and avoided her. Some of the staff regarded obstetrics as a sort of unwarranted intrusion. This never happened again, however.

The Naval Dispensary was within easy walking distance of the yellow Marine Hospital on the quay. No one will ever know the relief I felt when I was finally given full obstetrical privileges there, even if the facilities were minimal.

Then another obstetrician and gynecologist arrived, Dr. A. W. Diddle, now of Knoxville, Tennessee. He was board qualified, competent, intelligent, generous and mature. We quickly arranged an effective schedule to cover the situation efficiently and both of us were given a rotation at the dispensary so that we could learn something of naval medicine.

In 1942 we were frequently ordered to help manage casualties from ships torpedoed in the Caribbean Sea. One night the old Marine Hospital was overwhelmed with burned and injured when one of our destroyers, through failure of communications, ran into one of our mine fields.

The situation at Key West was always tense and troubled. One night a retired warrant officer and his wife, both drunk, drove their car off the sea wall near the dispensary and both drowned. Another night I was called to see a very drunk young Naval Aviation Ensign's wife after she had been to a party. Next morning she was dead. Her husband was away at the time. I saved the vomitus, sealed the cabinet and called the coroner. An unshaven, middle aged man in a visor cap appeared. "I hear you think there's been a suicide." He and the Ensign's commanding officer prevented me from performing a postmortem examination which I was burning to do. I think of the pathetic creature naked in the undertaker's establishment being viewed by the "coroner." The Ensign was subsequently killed in a plane accident. His parents made a trip to Key West to talk to me.

There was a great difference between the submarine personnel attached to the Sound School and the aviators at Boca Chica. I had little trouble with the submariners' families. They were, as a rule, steady, sober and devoted. The flyboys were volatile and given to indiscretions and alcohol. We had to cope with many more oppressive emotional problems among them.

*The sending of pregnant women elsewhere for delivery shattered a time-honored dictum of the day that travel by pregnant women frequently brought about spontaneous abortion. The experience of the Navy doctors at Key West resulted in a widely publicized paper showing this teaching to be incorrect.
See: Diddle, A. W.; Jack, Ralph, and Pearse, Richard L.: The Effect of Travel on the Incidence of Abortion, Am. J. Obst. Gynec. 48:354-360, 1944.

With Dr. Diddle and Miss Stauffer, we had a pleasant, efficient organization. The Navy procured forceps and special instruments for us. The collaboration with the Marine Hospital became more efficient and warm-hearted. Dr. Diddle delivered my wife of our second child in the Marine Hospital in February 1943, the last obstetrical venture in the history of the hospital.

Meanwhile, general surgeons, internists and pediatricians began to arrive. The Navy was going to put up a proper hospital with a special dependents unit included. The need for collaboration with the Marine Hospital ended when the splendid Navy Hospital was completed in 1943. A third obstetrician and gynecologist came to Key West, Dr. Ralph Jack of Miami, to head the new department and ultimately Dr. Diddle and I were transferred from the dispensary to the hospital. We enjoyed an adequate nursing staff, an air-conditioned delivery room, and all sorts of amenities. Dr. Charles Edelen gave all a rotation on the surgical watch. The esprit of the hospital was excellent under the benign and efficient chief medical officer, Captain Jesse Allen.

Still other memories rush to mind. The poor young woman riddled with bony metastases from carcinoma of the breast who had come to say goodbye to her husband before he left for the Pacific. The frightful day when one of the Sound School submarines sank like a plummet steaming home after the day's exercises. Only the captain and a few hands on the conning tower escaped. The threat of the hurricanes that never overwhelmed us. The fishing for langouste in the deep pool. Fausto's Food Store. Arroz con pollo. All the wonderful and interesting people, the gracious Pauline Hemingway, the artists, Doris Blake and Arnold Branch, Jack Dudley, the old China hand and many others. Finally, in November, 1943, orders to sea, which should have come long before they did.

▶ Dr. Pearse, 1821 Green Street, Durham, N. C. 27705.

A Doctor and an Island

Eugene L. Nixon

On a clear, cool December day the launch pointed southwestward over Apalachicola Bay. Thumbs in vest, the rotund, bearded physician in the bow squinted towards the broad, green island nine miles ahead. After the long and sooty train trip from Buffalo, the salty Gulf air was buoyant to body and soul. The spray felt warm as its droplets flecked the skin.

The time was about 1910, and Dr. Ray V. Pierce had come home again to the island he loved. In a short while, the boat would head up the creek near West Pass after carefully threading its narrow entrance. A few hundred yards beyond, the doctor and his party would climb the stone steps to the lodge he had built on the east end after purchasing the island in 1907 from the last of a succession of previous owners since it was deeded to an English trading company by the Indians in 1811.[1]

St. Vincent Island Today

St. Vincent Island today remains much the same as it was when occupied by Indians centuries ago. It is largely unknown except to a privileged few who have visited the area. The long period of private ownership and the relative isolation from population centers, combined with the absence of a bridge, have contributed to the island's anonymity. Lying off the Florida Gulf coast about half way between Apalachicola and Port St. Joe, the tear-shaped 12,000-acre jewel is probably one of the state's—and the nation's—finest natural assets. St. Vincent is approximately nine miles long from east to west and three to four miles wide from north to south. Its south shore faces the open Gulf of Mexico with broad, white sandy beaches. Its north side abuts St. Vincent Sound with heavy palm and pine forest to the water's edge, while its east portion has palm-lined beaches fronting on Apalachicola Bay.

There is considerable evidence geologically and biologically that the island eons ago was part of the mainland. Its topography, flora and fauna sharply contrast with those of the neighboring barrier reefs of St. George and Dog islands which, incidentally, are connected to the mainland by respectively a bridge and a ferry. The closest point of St. Vincent Island to the mainland is its western tip, which lies only about a third of a mile away across a coastal inlet known as Indian Pass. This narrow stretch of water with its strong tidal currents can be a formidable barrier to man, as the author and two fellow explorers discovered in their canoe in a 25-knot wind off the Gulf on their first visit to the island early in 1970. In Dr. Pierce's day, there was likely little attention paid to the western approach, in that access to it from Apalachicola was only by lengthy boat trip or



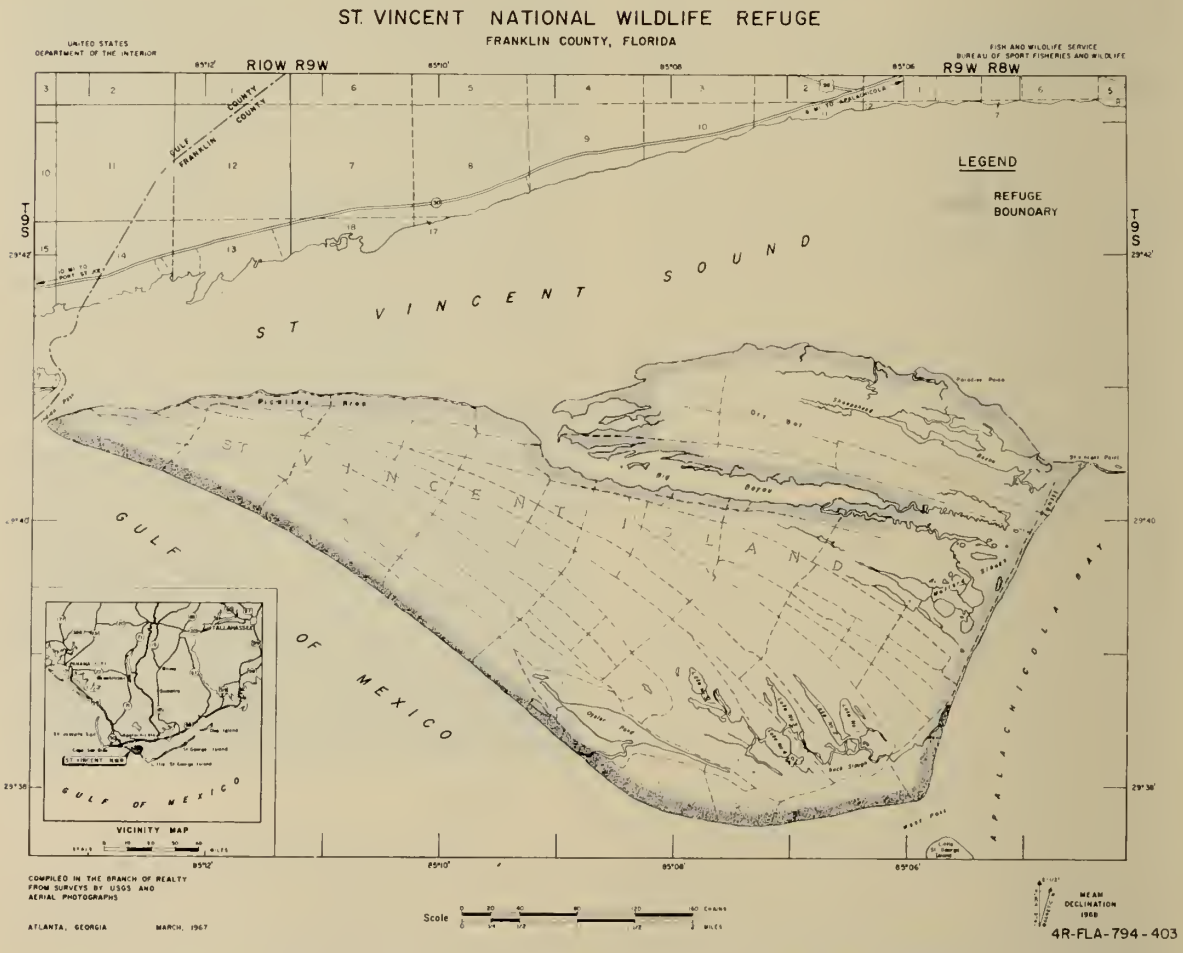
Dr. Ray V. Pierce, complete with signature (copied from "The People's Common Sense Medical Adviser").

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landward through more than 20 miles of dense woods and swamp. Today there is a paved road (U. S. 98, Florida Roads S-30 and S-30B) to Indian Pass.

The lush island contains six fresh-water ponds and several salt-water bayous, the largest of which, Big Bayou, is surrounded by acres of salt marsh. There are Indian mounds and relics in abundance. St. Vincent is both a biologist's paradise and perplexity. Throughout the island there are adjoining but highly contrasting habitats, such as fresh-water marshes and swamps, and dunes, hardwood hammocks and pine barrens. Thanks largely to Dr. Pierce, who built a network of trails and dirt roads for purposes of hunting and nature study, there is access to practically all parts of the island. Today as yesterday, there are all of the native plants and animals one would expect to see in this location in an area largely unspoiled by man. Bald eagles and ospreys nest seasonally. There are alligators in the fresh-water ponds and marshes. Many species of waterfowl, shorebirds, wading and pelagic birds regularly visit the island. White-tailed deer and wild turkey also abound. St. Vincent's Gulf beaches are a regular egg-laying area for the loggerhead turtle, but few hatchings are observed due to the depredations of feral hogs and raccoons, which find turtle eggs irresistible and delectable. Other species such as softshell, snapping and box turtles are found in great numbers on the island.

An exotic element was added to the island by Dr. Pierce, who introduced Sambar deer, a large swamp-dwelling Asian elk. A small herd, estimated at more than 75, remains today. Dr. Pierce and the only other subsequent private owners of the island also introduced zebra and eland from Africa and black buck from India, all of which either failed to adapt and/or were eventually removed from the island, with the possible exception of the black buck, two of which are reputed to have survived.



A map of St. Vincent Island, Florida. The Pierce lodge was located on the creek leading to the lakes in the lower right or southeast portion of the island.

Physician From Buffalo

How did a physician from Buffalo, New York, happen to own an island in Florida? To explore this question, one must learn a little about Ray Vaughan Pierce, who evidently was a truly remarkable individual. Born in Stark, New York, in 1840, Dr. Pierce received his M.D. degree from Eclectic Medical College in Cincinnati, Ohio, in 1865.[2]* He was not licensed until 1895, which is probably due to the fact that New York did not have a state medical licensure law until about that time. After practicing in Titusville, Pennsylvania, for a short period, Dr. Pierce moved to Buffalo in 1867, where he established what must have been a highly successful general practice from which he embarked upon a variety of profitable medical and nonmedical enterprises. St. Vincent Island obviously was his hobby and his vacation and retirement home.

In 1879, Dr. Pierce founded the Invalids' Hotel at 663 Main Street, Buffalo, which later became known as the Invalids' Hotel and Surgical Institute, perhaps reflecting an expansion of its services. Judging from the doctor's writings, his personal practice interest moved toward the field of gynecology, although his institution became a multi-specialty group practice. On Feb. 16, 1881, the original facility was totally destroyed by fire. Fortunately, all patients and staff were successfully evacuated with no injuries.[3]

Undaunted by this mild setback, Dr. Pierce immediately rebuilt and by 1884, the patient load was so heavy a sizable annex about the size of the first structure was constructed. According to Dr. Pierce, the Institute was ". . . just above and outside the business and bustle of this Queen City of the Lakes. It is easily reached from the railroad depots. . . . It is a substantially built brick building, trimmed with sandstone, well lighted and provided with a patent hydraulic elevator, so that its upper stories are quite as desirable as any, being more quiet than those lower down. . . . Nothing has been neglected that can add to the comfort and home-like make-up of this popular national resort for the invalid and afflicted."[4] Illustrations of the interior of the five-story Institute show it to have been lavish.

By this time, there were 18 physicians on the staff or "faculty," as Dr. Pierce preferred to call it, of an organization known as "World's Dispensary Medical Association." The second word in this imposing title is a clue to the next—and most widespread and long-lasting—of Dr. Pierce's endeavors, his patent medicine manufacturing business. Immediately to the rear of the Institute, there was a six-story structure called the "World's Dispensary," wherein were manufactured ". . . Dr. Pierce's Standard Family Medicines, as well as all the various Tinctures, Fluid Extracts and other pharmaceutical preparations used by the staff of physicians and surgeons of the Invalids' Hotel and Surgical Institute in their practice. . . ." From these laboratories came such famous tonics as Dr. Pierce's Golden Medical Discovery, which was said to relieve indigestion and coughs and to keep the bowels moving; Dr. Pierce's Pleasant Purgative Pellets, clearly a cathartic; Dr. Pierce's Favorite Prescription, another tonic in liquid or tablet form consisting of Lady's Slipper Root or American Valerian, Viburnum, Black Cohosh Root, Unicorn Root, Blue Cohosh Root and Oregon Grape Root, and a large series of other products, all of which were available by mail order to 665 Main Street, Buffalo.[5] Many of these medicines could still be purchased in drug stores as recently as 1969.[6]



A view of the northwestern shore of St. Vincent Island on St. Vincent Sound (photograph by author).

Diagnostic Services

Another part of Dr. Pierce's extensive operations was his "outreach" diagnostic service. Although it was always stressed that members of the medical staff had all the work they could handle in the home institution, it was possible for a pa-

*There is some confusion on the year of his graduation. One source states 1862. The author accepts the American Medical Association's records which indicate it was three years later.



A road on St. Vincent Island (photograph courtesy Florida Game and Fresh Water Fish Commission).



The creek leading to the Pierce lodge on St. Vincent Island. Dr. Pierce's launch used this waterway going to and from Apalachicola, nine miles across the bay (photograph by author).



The steps which Dr. Pierce climbed upon arrival at his lodge on St. Vincent Island. The creek in left background in 1972 is heavily overgrown with cattails (photograph by author).

tient in Keota, Iowa, for example, to fill out a rather extensive questionnaire of history and symptoms which was analyzed and answered without charge by a member of the medical staff. In lieu of a charge, persons seeking such consultation by mail were requested to send the names of ". . . all those within the circle of their acquaintance that are in any way in need of medical or surgical treatment for chronic diseases."[7] Patients also were invited to send (express prepaid) samples of urine for microscopic examination and chemical analysis. The fees started with the consultation and were payable in advance monthly. They varied with the individual regimen and whether or not the patient was ordered to come to Buffalo or was treated by long distance.[8]

Dr. Pierce's "Bible"

A keystone and the "bible" of Dr. Pierce's medical activities was his "The People's Common Sense Medical Adviser," an illustrated hardbound volume of more than 1,000 pages. It was written by Dr. Pierce and his staff and published and printed at "The World's Dispensary Printing Office and Bindery," another Pierce subsidiary in Buffalo. Untold thousands of copies of the book were sold at $1.50 per copy over several decades throughout the U. S., Canada and Great Britain. Revised and reprinted many times over, the volume contained detailed chapters on anatomy and physiology, descriptions of diseases and discussions of family health problems, many of which features would do credit to contemporary family health guides. As might be expected, the book also contained complete and highly favorable descriptions of the Invalids' Hotel and Surgical Institute, including numerous testimonials from patients.

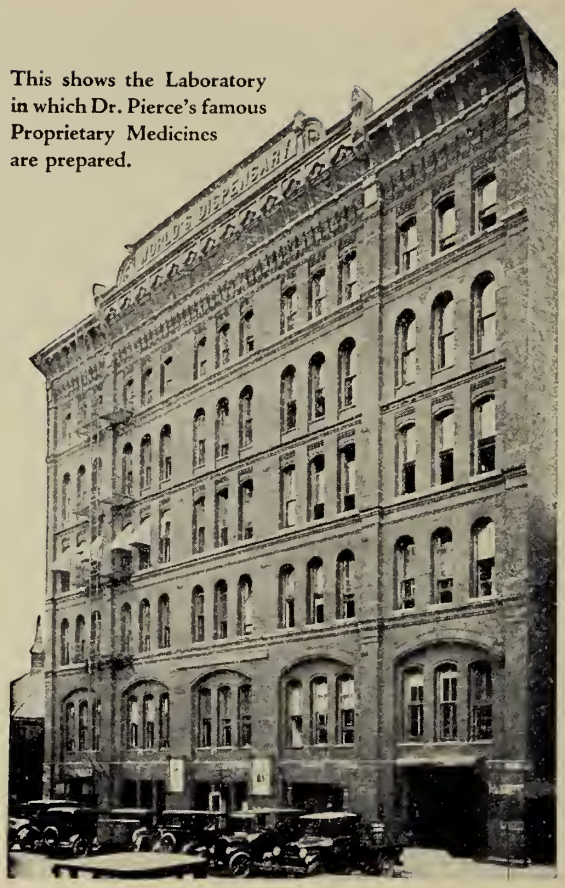
The entire volume was laced throughout with Dr. Pierce's philosophies, such as on advertising: "Having thoroughly qualified himself for the practice of some brand of the healing art, the specialist sees no impropriety in acquainting the public with his ability to relieve certain forms of suffering. He believes that medical men should possess equal rights with other business men, and that any code of medical ethics which would deprive him of any of the sacred rights guaranteed to all by the liberal laws of the country, is professional tyranny, and merits only his contemptuous disregard."[9] Little wonder that Dr. Pierce is remembered in the Buffalo area as a "flamboyant character."[10]



St. Vincent Island's wide beach on the south or open Gulf side (photograph by author).



Part of a guest cottage still standing at the Pierce lodge site on St. Vincent Island. The anachronistic sign reads, "Property of U. S. Government. No trespassing" (photograph by author).



This shows the Laboratory in which Dr. Pierce's famous Proprietary Medicines are prepared.

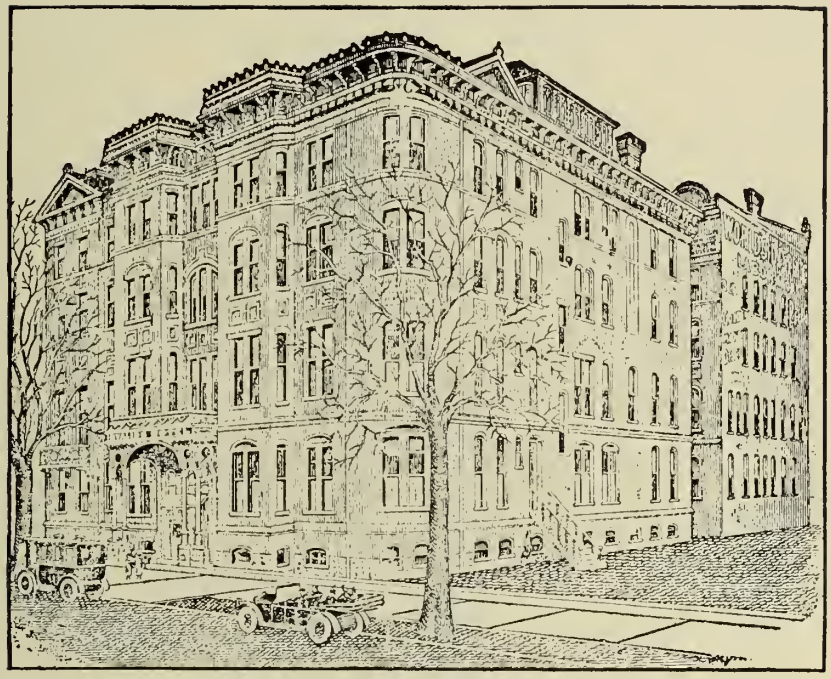
This building is located on Washington St., Buffalo, N. Y., just back of Dr. Pierce's Invalids Hotel, which is at 665 Main St.

Despite the expansive, far-flung nature of his practice and business, Dr. Pierce kept its control within the family. His close associate and heir apparent was his son, V. Mott Pierce, M.D., who was born in 1865 and graduated from the University of Buffalo School of Medicine in 1891. His brother's son, Franklin D. Pierce Jr., M.D., who was born in 1877 and a graduate of Syracuse University College of Medicine in 1904, also was brought into the Pierce medical empire. Dr. Ray Pierce's brother Franklin joined him and his son in forming the Pierce Development Company in 1903 which owned a glass works and a natural gas company in Pennsylvania and about 20,000 acres in northern Alabama, where they established the Pierce Coal and Lumber Company, complete with a company town named Pierceton.[11] It was the Pierce Development Company which purchased St. Vincent Island.

After wintering happily at St. Vincent Island for seven years, Dr. Ray V. Pierce died there Feb. 4, 1914, at age 74.[12] Dr. V. Mott Pierce, who inherited the estate, continued to operate the family interests and to visit the island. He eventually retired and died in 1942 at age 77 in Pasadena, California.[13] The Pierce estate held St. Vincent until 1948, when it was sold to its last private owners, Alfred and Henry Loomis, of New York City and Middleburg, Virginia, respectively, who continued the Pierce's policy of leaving the island as nearly as possible in its natural state. The two families owned St. Vincent for 61 years.

Wildlife Refuge

Thanks to the last private owners' desire not to allow the island to fall into the hands of developers, it was sold to the Nature Conservancy in 1968, which transferred the title to the U. S. Department of the Interior, Bureau of Sport Fisheries and Wildlife. Now included in the National Wildlife Refuge System, it is officially designated the St. Vincent National Wildlife Refuge. In addition, it has been declared a wildlife man-



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The Invalids Hotel is not a Hospital, but a Pleasant Remedial Home organized with a Full Staff of Physicians and Surgeons for the Treatment of all Chronic Diseases

We have not the space to speak, individually, of the large number of professional gentlemen composing the Faculty of this old and world-famed Institution, but will say that among them are those whose long connection with the Invalids Hotel and Surgical Institute has rendered them *experts* in their several specialties. Several of them have previously distinguished themselves in private practice, and have filled responsible positions in both military and civil hospitals.

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if in need of remedial treatment for any form of chronic ailment, whether requiring medical or surgical means for its relief. If you cannot come, send us a complete history of your case, or write for one of our question blanks. It is well also to send a sample of urine for our chemist's examination, for while, in many cases, no light may be thrown upon the nature of an ailment by such examination, yet, in diabetes, Bright's disease and some other affections, valuable knowledge is thereby gained for the sufferer's benefit.

We make no charge for consultation by mail. Write and describe your symptoms, sign your name *very plainly*, giving also your Street or Box number, Post-office, County and State, and our terms for treatment and all particulars will be sent you. Address

WORLD'S DISPENSARY MEDICAL ASSOCIATION

DR. V. M. PIERCE, President, 665 Main Street, BUFFALO, N. Y.



Three of Dr Pierce's most popular pharmaceutical items (photograph by Gene Smith).

agement area by the Florida Game and Fresh Water Fish Commission.

At this writing, the Refuge is managed by a staff and office located in Apalachicola. Visits to the island are permitted, provided visitors register first with the Refuge office. Environmental education and research groups are encouraged to visit. Fishing in the fresh-water ponds is permitted, but only by the "primitive" concept: no motors are allowed (the Refuge staff calls it "paddle and pole"). Hunting is rigidly controlled and is done only as a wildlife management tool; wild hog and deer hunting by bow-and-arrow and muzzle-loading rifles are allowed only on a limited number of days per year. Surf-fishing, bird-watching, shell-collecting, hiking, photography and simple "nature study" are permitted. All wildlife observation pursuits are encouraged as "nonconsumptive use."

Future plans for St. Vincent include no bridge ever from the mainland. A tract of land on the mainland near the island's west end has been acquired for a new Refuge headquarters and visi-

tor center, where there will be diagrams and models. It is anticipated that only a small percentage of future visitors will actually go over to the island. Part of the new headquarters area will be devoted to a protected boat harbor for Refuge marine equipment and a public boat launching ramp.



A softshell turtle on St. Vincent Island. This two-foot-long specimen did not care to share the road and was not disputed (photograph by author).



St. Vincent National Wildlife Refuge Assistant Manager and wildlife biologist Don Temple beside one of the fresh-water ponds on the island he loves (photograph by author).

The future plans for St. Vincent are best described by the following new objectives which have been submitted to the Department of the Interior by the Refuge manager, Charles F. Noble:

"The first purpose for establishment was for migratory waterfowl management in future years when wetland habitat in northwest Florida becomes depleted. Reflecting changing priorities and refuge policies, St. Vincent has become an important refuge for (1) protection of endangered species habitat, (2) retaining unchanged biocommunities by establishing protected natural areas, and (3) developing a primitive area public-use concept providing extremely high quality wildlands-wildlife experience in a natural environment."

The author and his biologist-wife most recently visited St. Vincent Island in April, 1972, and were given an extensive tour of most of the island by assistant Refuge manager Donald Temple, a young wildlife biologist whose love for the island and its life was constantly apparent. It also was abundantly apparent that little had changed from Dr. Pierce's day, nor was it likely to change.

Acknowledgment

The author wishes to acknowledge with appreciation the assistance rendered by Mr. Gene Smith, editorial assistant, "Florida Wildlife," for considerable research and valuable photographs; by Dr. William M. Straight of Miami for encouragement and the loan of a copy of "The People's Common Sense Medical Adviser" and other documents and materials relating to Dr. Ray V. Pierce; by Mr. Samuel Aker of Miami Beach for the loan of clippings, documents and pharmaceutical formulae of the period, and by Mr. Donald Temple, assistant manager, St. Vincent National Wildlife Refuge, for giving up considerable personal time for this project.

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James M. Jackson, Jr. Miami's First Physician

William M. Straight, M.D.

In the 1890's Florida's leading industry was the growing of citrus. The fall of 1894 promised a bumper crop, but on December 24, and again on December 28 freezing weather swept over the state with "light frost temperatures even to Key West."[1] Then the weather warmed and the sap rose again in the trees. On Feb. 6, 1895, freezing weather again blanketed the state. This time not only were the leaves and fruit destroyed, but the sap laden trees themselves fell victim and over 90% of the state's citrus trees were destroyed.

Perhaps more than any other single event of that period this freeze spurred the development of Dade County. The fact that Miami escaped the freeze encouraged Henry M. Flagler to build his railroad south from Lake Worth and to erect Miami's first luxury hotel, The Royal Palm, on the north bank of the Miami River at its mouth. This freeze was also directly responsible for bringing to Miami the young physician, James M. Jackson, Jr., the first physician resident within the incorporated limits of Miami.

Young Jackson was at that time in practice with his father at Bronson in Levy County, Florida. Bronson was an up and coming town of approximately 5,000 souls on the railroad from Jacksonville to Cedar Key, the "Mullet Express" as it was locally called. When the great freeze destroyed the citrus industry, people left in droves as their livelihood was cut off. The remnants could scarcely support one physician, so young Jackson began to look for a place elsewhere. At this time he met Flagler's right-hand man, J. R. Parrott, who offered him the position of Florida East Coast Railroad Surgeon at the soon-to-be terminus of the railroad on Biscayne Bay. Thus in April 1896, Jackson, leaving his wife with her family in Bronson, set out "to look things over" at Miami.

By rail he made his way to Ft. Lauderdale, then the terminus of the railroad, and from there he travelled aboard a small steam launch to the Miami River. As he stepped onto the wharf at the foot of Avenue D (South Miami Avenue), on the north bank of the river to his left was moored the old steamboat Rockledge, once the queen of the Indian River but now Captain E. E. Vail's Floating Hotel. Accommodating about 50 people it was one of the few public hostelries available. Further up the sand road on his left were tents, shacks, a large gospel tent which served for church and town meetings, and the Miami Metropolis Building (southwest corner of Miami Avenue and Southwest First Street) which housed the village's newspaper. To his right were Adam Correll's Livery Stable, several wooden store buildings displaying the names: A. E. Kingsley, Real Estate; Frank T. Budge, Hardware; S. A. Belcher Co.; Salem Graham's Bakery, and further on, the three story wooden Miami Hotel still under construction.

In less than an hour Jackson walked the length and breadth of the fledging Miami. Up Avenue D to Twelfth Street (Flagler Street), east until Twelfth Street dwindled into a footpath that led to the bay, south past Thirteenth Street (Southeast First Street) which boasted the Miami Hotel and several cottages, and on to the bank of the Miami River. On the north bank were the barracks and officers quarters of Fort Dallas, a relic of the Seminole Wars. The fort faced a partially overgrown parade ground edged by a dense tropical hammock. On the south bank at the river's mouth was the home and store of Ole Man Brickell. The town's post office was in the Brickell store and early Miami residents griped that they had to pay the ferryman ten cents to be carried across the river and back just to get their mail.

The town was one of unpaved dirt streets with here and there outcropping coral rock to bruise the feet or jar the wagon. Some of the business buildings had short stretches of boardwalk as an accommodation for their customers and to reduce the sand dragged into the store. All of the buildings were of frame construction and

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the only building graced with a coat of paint was the Miami Metropolis Building. The people Jackson talked with seemed friendly, but his inquiries left the impression that Miami was an expensive place to live. Town lots sold for $100 to $1,000 depending on location. Lots in North Miami (north of Eleventh Street—Northeast First Street) sold for $50 to $100 but could be had "on payments." In Southside, Mary Brickell's subdivision south of the river, lots cost about $300.

Disappointed with what he saw, Jackson made his way back to the landing to inquire the next boat to Ft. Lauderdale. He was told there was no scheduled transportation out of Miami until the train arrived and this was expected in a few days. Resigned to staying, he found a room at the Miami Hotel and settled down. In the ensuing days he met several of the leading young men of the community and became impressed with their ability and enthusiasm. He wrote his wife, "This Miami spirit is a great thing. It is infectious." When the first train arrived on April 15, 1896, Jackson was there to greet it and had already decided to cast his lot with the young town. When on July 28, 1896, the city was incorporated, Jackson was the sole physician living in the city.

Medical Training

James Mary Jackson, Jr. was born the only child of James Madison Jackson and Mary Glenn Shands at White Sulphur Springs, Florida, on March 10, 1866. His parents were from Chester County, South Carolina. A year or two after his birth they moved to Bronson where his father engaged in the practice of medicine, established a drugstore, and owned citrus groves. After preliminary education at Bronson, Jackson entered the East Florida Seminary then at Gainesville. The East Florida Seminary was styled as "an ungraded public school . . . to prepare boys and young men for admission into university classes, or for entrance at once upon the active duties of life."[2] It was one of the forerunners of the University of Florida.

Having completed the course of study at the seminary, Jackson went on to Emory University, then at Oxford, Georgia, where he graduated with a Bachelor of Arts degree in 1885.

That summer when he returned to Bronson his father tried to persuade him to take over the management of the citrus groves but Jackson hankered to be a doctor. Furthermore he had



"A year or two after his birth they moved to Bronson . . ." From left to right: a servant, Dr. James Madison Jackson, Sally Shands, Mary Shands Jackson.



". . . Jackson entered the East Florida Seminary, then at Gainesville."



". . . he entered Bellevue Hospital Medical College . . ."

support from his mother who felt he was "cut out to be a doctor." Thus in the fall of 1885 his mother sewed six $100 bills into the lining of his good coat, and he set out by train for New York City. There he entered the Bellevue Hospital Medical College, the first successful medical school-hospital-dispensary combination in this country.

Life in medical school in 1885 was a bit rougher and more boisterous than it is today. There were no specific requirements for entrance, although most of the students had attended high school for at least a few months. Hard drinking, heavy smoking and frolicking with women of doubtful virtue were a point of pride among the students. Jackson had been brought up in a strict Methodist home and neither drank nor smoked. Further he was much too dedicated to fritter his time away with loose women. He did join his classmates at the neighborhood beer parlor on Saturday nights and the standard rib was for a classmate to shout in a loud voice, "a sarsaparilla for Jackson."

Lectures were given in a stifling, dusty and dimly lit amphitheater. The students sat on backless, wooden benches inhaling air thick with tobacco smoke and the aroma of infrequently washed bodies. As the professor droned through his lecture, often two or three hours long and not even enlivened by lantern slides, the students became restless and often resorted to whistles, catcalls, and foot stomping to break up the session. More interesting were the outpatient surgical clinics conducted by Alexander Mott, son of the renowned Valentine Mott. Standing majestically in his Prince Albert with the sleeves turned back to show his fine linen cuffs, Mott, oblivious to the new science of bacteriology, operated on one patient after another on an old wooden physiology experiment table. On this one he lanced an abscess, on that one he removed a wen, and on the third he amputated a mangled finger. Between patients he wiped his scalpel on a blood and pus stained cloth and placed it between his lips as he dressed the wound. When sutures or ligatures were called for, he selected one from several waxed linen threads which he kept in the buttonhole of his lapel.[3] The Carnegie Bacteriology Laboratory under the direction of Edward G. Janeway had opened at Bellevue the year prior to Jackson's matriculation, but Mott considered this an unproven theory and a nuisance. However, not all Jackson's teachers took this attitude for William T. Lusk, Professor of Obstetrics and Gynecology,

was an enthusiastic follower of Lister and had lectured on the germ theory of disease as early as 1876.[4]

At the end of his first year Jackson returned to Florida and successfully passed the Florida State Board Medical Examination. Now his father insisted that he settle down to practice in Bronson and stop this unnecessary drain on the family's economic resources. Jackson had other plans, he wanted the M.D. degree and this required another year of study. With the financial support of his mother, he returned to Bellevue that fall and graduated the following spring. Now a full-fledged M.D. he returned to Bronson and engaged in medical practice with his father until the fateful freeze.

In the Proceedings of the Florida Medical Association for 1892, pages 119-123, appears his first and only scientific paper, "Relation of Phosphate Mines to Health of the Operatives and Surrounding Country." In this short paper the young physician speculates on the possible production of kidney trouble by the drinking of phosphate laden waters and exposure of the kidney region to the direct rays of the sun by workers in phosphate mines. He also suggests that abandoned phosphate pits filled with water breed malaria. He does not mention mosquitoes although several people had previously suggested that mosquitoes might transmit malaria. It was five years after Jackson's paper that Ronald Ross unequivocally demonstrated the mosquito transmission of malaria.

Marriage and Practice

At half past nine on the morning of Oct. 3, 1894, in the Methodist Church of Bronson, the young doctor married his childhood sweetheart, Ethel Barco. We cannot say what the bride wore for the Levy Times-Democrat reporter, a man not versed in ladies' fashions, refused to attempt a description of her dress, ". . . even for the best orange grove in the county."[5] The account concludes, "They left on the first train for a tour to New York and up the Hudson, and will touch at Washington and other places." Their marriage was blessed with two daughters and a son: Ethel, born April 4, 1897, and Helen, born Jan. 14, 1901. The son died soon after birth and in the First United Methodist Church is a beautiful stained glass window dedicated to the infant by his loving parents.

In September 1896, Jackson met his wife in Jacksonville and brought her to Miami to take up temporary residence in the Miami Hotel. Although the hotel did not ordinarily supply doors for guest rooms, as a special dispensation for the newlyweds a door was found and set in place. It could not be hung for hinges were not available in Miami at that time. After a few weeks at the Miami Hotel they moved to a loft above a store on the west side of Avenue D. Jan. 1, 1897, they rented the Blackman cottage on the northwest corner of Avenue C and Eleventh Street (Northeast First Avenue and First Street). Of this cottage Jackson later said, "I paid twenty-five dollars a month for that place and I had to go out of doors to even breathe." Later that year they moved to a house on the southwest corner of Twelfth Street and Avenue B (Flagler Street and Southeast Second Avenue). Sitting on the porch of that house and gazing at the pine land across the intersection, Mrs. Jackson talked the good doctor into buying from Mrs. Tuttle the large northeast corner lot (one hundred feet on Twelfth Street and one hundred forty feet on Avenue B) for $2,500. Here in the summer and fall of 1899 they built a spacious house in which they lived for about 20 years. Behind this house and fronting on Avenue B Jackson built a small office and "surgery" in 1905. When this property was leased in the late "teens," these two buildings were barged down the bay a short distance and set up side by side on the present Southeast Twelfth Terrace. There they may be seen today; the office is at 190 and the house at 186. With the leasing of the Twelfth Street property they built their final home, Homewood, a lovely masonry home on the bluff overlooking Biscayne Bay at 1627 Brickell Avenue.

Jackson came to Miami as the railroad surgeon and soon after the Royal Palm Hotel opened, Jan.



". . . in the summer and fall of 1899 they built a spacious house . . ."

16, 1897, he became the hotel physician. In May, 1896 he was appointed local agent for the Florida State Board of Health and became a trusted and loyal friend of the first State Health Officer, Dr. J. Y. Porter. In this capacity he inspected all ships that stopped at Miami, organized the fight against epidemics such as measles, dengue fever, smallpox and yellow fever, and he periodically issued health directives to the citizenry. In the Miami Metropolis, June 19, 1896, page 1, we find, ". . . all householders and tenters must use galvanized iron slop buckets in all closets, pour all kitchen slops and refuse in buckets—all of which must be carried and thrown into the river . . ." Later that year Miami city ordinances were drawn up prohibiting the throwing of dead animals, filth, or garbage into the river, bay or any watercourse on pain of "a fine not exceeding twenty-five dollars, or be imprisoned in the common jail or calaboose not exceeding twenty days."[6] It was also Jackson who organized the Miami City Board of Health in 1914.

From the very beginning of his professional life he took an active interest in organized medicine as a way to upgrade the medical care of the people of Florida. He was a founder member of the Dade County Medical Association and its President in 1905, 1912 and 1923. He was inaugurated as President of the Florida Medical Association in 1905 and in his Presidential Address delivered at Gainesville, April 1906, he pleads for unity among the physicians of Florida, emphasizes the need for continuing education, and rails against the sexual license of his day and the diseases it spawned.[7] He was an early member of the Southern Medical Association and elected to its Presidency at the Hattiesburg, Mississippi meeting, November 1911.[8]

Not only did he concern himself with the health needs of the community, but he also took an active part in social, business and religious affairs. He was a charter member and generous supporter of Trinity Methodist Church (First United Methodist Church of Miami), chairman of the fund drive for the downtown Y.M.C.A. building, chairman of the board of the Y.M.C.A for many years and an enthusiastic booster of Scouting for both boys and girls. He was the first Worshipful Master of the Miami Masonic Lodge and a founder member and first President of the Downtown Miami Rotary Club. As a businessman his faith in Miami led to several wise property investments and he was a major stockholder and chairman of the board of the ill-fated Bank of Bay Biscayne. He prided himself that his word was his bond and lost a valuable interest in a piece of property when he accepted a "friend's" word instead of insisting upon a signed contract. Socially, he and Mrs. Jackson were always present for the gala opening of the Royal Palm Hotel each season and for similar functions. He was Fleet Surgeon of the Biscayne Bay Yacht Club but was apparently not an avid yachtsman. Each fall for many years he returned to Bronson or Gainesville to hunt deer with relatives and childhood friends.

Professionally, he was clearly the leader of the local medical profession. Physicians who remember him describe him as a keen observer, careful thinker, and man of good judgement. He was a very capable surgeon for his day and a man of deep religious conviction. One pioneer recalls a Sunday when he rose and asked the congregation of Trinity to pray for the survival of a young man with a ruptured appendix whom he planned to operate on the following day. As was the custom here at that time, he operated with an ice collar around his neck during the summer months. He often took atropine to reduce his sweating during operations. For many years he wore a mustache but one day as he was operating, a hair fell from it into the wound so he promptly shaved it off.



"Professionally he was clearly the leader of the local medical profession."

It must be remembered that the wearing of surgical masks was not the custom at that time.

He maintained an excellent medical library and made good use of it. Once a year or more often, he journeyed to a medical center somewhere in the East or Middle West for a week or more of postgraduate education. In his President's Address to the Florida Medical Association he exhorts his colleagues, ". . . one must to be a successful physician be always a student . . ." Always receptive to new ideas, he apparently owned the first radiographic equipment in Dade County.[9]

His first office in Miami was in the Miami Hotel. In December 1896, he moved to quarters behind the Townley Brothers Drugstore on the southeast corner of Avenue D and Twelfth Street. In late 1905 he built an office and surgery behind his house and facing Avenue B. When he leased the Twelfth Street property as part of the contract he acquired a lifetime, rent-free office in the building which was erected there.

Hospitals

The most serious epidemic to strike the infant Miami was yellow fever which appeared in early September 1899, in the person of a Mr. S. R. Anderson. Jackson, the County Health Officer, quickly moved Anderson and his family to a schooner anchored down the bay. However, 18 days later another case appeared at the Miami Hotel, Mr. Hargrove. Then cases began to appear on all sides and Miami was quarantined. In all there were 220 cases with 14 deaths. At first the Miami Hotel, considered already contaminated, was used to isolate the patients, but soon it would not suffice. A public spirited citizen, W. W. Prout, at his own expense erected a frame building, 18 x 88 feet, on property he owned between Seventh and Eighth Streets on Avenue C (Northeast Fifth and Fourth Streets on First Avenue). Jackson and J. Y. Porter were in charge of this emergency hospital. This was Miami's first civilian hospital and housed 40 patients, both black and white, and despite its cost of $1,000 it was burned to the ground when the epidemic ended Jan. 15, 1900.[10] Incidentally, the Miami Hotel mysteriously caught fire and burned on November 16. Some suspected arson born of the fear that it was infected with yellow fever miasmas.

In 1903 a similar pest house was hastily constructed on property bought by the city council when smallpox broke out among waiters of the Royal Palm Hotel. This hospital, two and one-half miles from town at the present Northwest Seventh Avenue and Twenty-eighth Street, functioned under Jackson's administration for about two months. Later the Florida State Board of Health constructed a more ample pest house on the same site which functioned when needed and under Jackson's guidence from 1904 until about 1914.

The need for a civilian hospital within the city limits was recognized early. Tourists and indigents became ill and Miami had no place where they could be cared for. As early as 1900 Mr. Flagler erected a frame hospital building on the corner of the present Northeast Ninth Street and Biscayne Boulevard with the proviso that the city equip, staff and administer the hospital. The city was not able to raise the needed funds so Flagler converted the building into an apartment house. When in December 1905, the railroad began to push south from Miami and brought into the area large work gangs, the apartment house was reconverted to a hospital and Jackson put in full charge. Jackson took his private patients there and under certain circumstances other physicians were allowed to see patients there. Sometime prior to World War I it again ceased to function as a hospital and Jackson bought it and converted it into living quarters for service personnel. Jackson played little role in the establishment of the Friendly Society Hospital in 1909 on the corner of the present Northeast Eighth Street and Biscayne Boulevard. It was this hospital that was the forerunner of the present Jackson Memorial Hospital. However, during the years 1916 to 1918 Jackson was an active planning committee member and consultant for the building of the present Jackson Memorial Hospital.



"In late 1905 he built an office and surgery behind his home facing Avenue B."

Annoyed as we are by torn up streets and bridges, think what Jackson had to tolerate as Miami struggled to become of age. As we have seen, upon his arrival Jackson found a village of dirt streets and pothole riddled wagon ruts. In the summer of 1896 the grading and paving of Twelfth Street began initiating 18 months of blasting, scraping and rolling. This resulted in streets whose surface was powdered rock which emitted a blinding glare and a choking dust. In April 1901, this nuisance was mitigated when the city purchased a sprinkler wagon. Also in June 1896 the county commission ordered the building of a 12 foot wide rock road to start at the ferry landing on the south bank of the river opposite Avenue D, then proceed to the road built by Mr. Brickell (part of the present Brickell Avenue), then past the Punchbowl, and on to Coconut Grove. According to John Sewell the first bridge across the Miami River appeared about 1898 and was a wooden bridge with a sliding draw. This bridge was at the foot of Avenue G (Southwest Second Avenue).[11] Later roads were extended in all directions and other bridges were built culminating in the wooden causeway built by John Collins to Miami Beach which opened for traffic on June 12, 1913.



". . . Jackson bought his first car and became Miami's third automobile owner." Shown with his daughter, Helen, in front of the Royal Palm Hotel.

Transportation

Early Jackson acquired a horse and buggy, possibly the rig seen standing beside his office in the accompanying photograph. His houseboy, King, who lived south of Twelfth Street and west of the railroad tracks, usually drove him on his calls. However, at night rather than send for King or hitch up the rig himself, Jackson often rode a bicycle. On July 8, 1898, the newspaper records that some ingrate had purloined the good doctor's bicycle from its accustomed place beside the office door.

The first mention of an automobile in Miami appears in the Miami Metropolis, April 5, 1901, a note under "Miami Mincemeat," "The locomobile will run for the next two weeks at the same rate as hacks or carriages. Moonlight trips a specialty. Trips to the golf grounds and back for 25¢ per person." This conveyance was operated by J. C. Rice. In November 1903, the Metropolis notes that Mr. L. C. Oliver made the trip to Coconut Grove and back in forty-five minutes in his "Ford Motor Company machine" with its eight horsepower motor. Some time prior to 1907, according to Pat Railey, Jackson became Miami's third automobile owner. The car pictured in front of the Royal Palm Hotel may be that automobile. It has been variously identified as a Ford Model C or a Brush. Having made the jump to the horseless carriage, he seems to have retired his horse and buggy.

It is likely that Jackson and family motored to the golf grounds on July 21, 1911, to see the first "aeroplane" flight at Miami. The newspaper writer of the day gives a graphic description of the large "bi-plane" with its powerful thirty-five horsepower engine. He describes the takeoff: ". . . at a fast rate the bi-plane glided across the green for about a hundred yards, and then as easily as the rise of a partridge, the graceful machine went upwards through the air."[12]

Then there was the problem of sewage disposal in the rapidly growing city. As we have seen this began with Jackson's directive ordering "householders and tenters" to empty their slop buckets into the river. In December 1896, in preparation for the opening of the Royal Palm Hotel sewer and water lines were laid along Avenue D and down Fourteenth Street (Southeast Second Street). In January 1902, Flagler presented the city with a $15,000 sewer system and in 1910

this was updated by the building of a "trunk line" system connecting with most of the old system and emptying into Biscayne Bay "400 feet from the end of Second Street (Northeast Tenth Street) . . . into a channel that carries all deposits into the ocean . . ."[13]

Although most of the old residents like Jackson probably knew where everybody of importance lived, newcomers and visitors had difficulty locating people. Therefore in October 1902, all business houses and residences were numbered. Now with proper addresses mail collecting began on December 7, 1903. When the Miami Telephone Company began service, Feb. 24, 1899, Jackson became the first physician subscriber. The first electric power generator in Miami was the one installed in the Royal Palm Hotel. Power became available to the business houses and residents of the town first in 1899 by a contract negotiated by the city with the hotel. In 1904 the city constructed its own generator.[14] Jackson's home on Twelfth Street was one of the first private residences equipped with electricity.

The availability of electric power made possible the Miami Street Railway which began operation July 25, 1906. This, Miami's first streetcar system, initially ran east on Twelfth Street from the railroad tracks to Avenue B, then north to Sixth Street where the depot was then located. So sharp was the curve at Avenue B that an "old Negro employed by the company came out and greased the track . . ." before each trip of the car. Possibly the screeching of the wheels as the car made the tight curve alongside his home and office ruffled Jackson's nerves and led to this greasing procedure.

Habits and Illness

Jackson was fussy about his dress but not fopish. In the winter he wore dark suits, a vest and a dark hat. In summer he preferred white palm beach suits, stiffly starched shirts (fresh morning and evening), a starched linen wing collar, a four-in-hand pique tie with a stickpin in the knot (as the custom then was), and white socks and shoes. An idiosyncrasy vividly recalled by several pioneers was his stiff-brimmed, white straw, sailor hat from which he removed the crown to provide better ventilation. Another element of dress which impressed his patients was the customary flower in his lapel, often a white jasmine. He was an inveterate cigar smoker and preferred a five cent cigar known as the "Cinco." He often referred to these as "stinkos" and with considerable accuracy. When he entered a patient's house it was his custom to leave the cigar resting on the porch rail or the edge of the porch floor. Often upon his departure he would forget to retrieve it and you could follow Jackson's path around town by spotting the cigar butts.

He was a man of medium height, slender build and a warm enthusiastic disposition. He walked with a quick step and had a quick decisive mind. Yet as he walked the streets of Miami he found time to speak a few words to both friend and stranger. One pioneer who as a child lived near Jackson's home recalls his facility at remembering the names of all of the children and his willingness to talk with them when they met him on the street. He seemed to enjoy life and was a master at telling rib-ticklers when the occasion presented itself. He was unpretentious and equally at home presiding over the board meeting of the Bank of Bay Biscayne or sitting at the bedside of an indigent patient. He had but one standard of service for all, his very best.

For a number of years Jackson suffered from indigestion. A diagnosis of peptic ulcer disease was made and in 1922 a gastroenterostomy was performed. This verified the diagnosis and relieved his symptoms. In August 1923, he developed bronchopneumonia which he attributed to wearing an ice collar around his neck while operating. With the usual treatment he improved but the cough would not relent. He had two or three asthmatic attacks and lingering dyspnea. In the early winter he lost his appetite, began to lose weight and grow weaker. In February 1924, he went to Baltimore to consult his long-time friend, Dr. Lewellys Barker, who made a diagnosis of Streptothrix infection of the lung after growing this fungus from his sputum on hydrocele agar. On February 23, he was admitted to the Johns Hopkins Hospital for intravenous mercurochrome (220) therapy. Initially he received two injections, 64 ml. each, of ½% Gentian Violet. As these gave no perceptible reaction, the following day he received the first of two doses of intravenous mercurochrome 1%, 5 mg. per kilogram of body weight. This resulted in nausea, vomiting and diarrhea. The vomitus and stools were stained with mercurochrome. On March 3, a chest x-ray showed a right pleural effusion and the radiologist, Dr. Walter Baetjer, noted "tumor cannot be excluded." A thoracentesis on March 6 produced a pint of "cloudy fluid with greenish opalescent (sic), this is probably mercurochrome."[15] At this point Jackson elected to

return to Miami. Dr. E. Clay Shaw, a urological resident, was sent to Miami to continue the mercurochrome therapy. Jackson accepted one more treatment then decided the cure was worse than the disease and dismissed Shaw. He died April 2, 1924 at Homewood at age 58.

All Miami went into mourning. Stores displayed his portrait draped in black crepe. On the day of his funeral, April 4, Mayor E. C. Romfh proclaimed that all business houses close from eleven to one, and that the schools let out so that the children might attend the funeral with their parents. The services at Trinity Methodist Church were attended by more than 900 people from all walks of life. Such greats as the silver tongued orator, William Jennings Bryan, eulogized Jackson. John B. Reilly, Miami's first Mayor, said of him: "He was one of the community's greatest friends and was always ready and willing to do all he could for others. His death is a great loss to the entire city." He is buried in the City of Miami cemetery on Northeast Second Avenue at Eighteenth Street.

On April 8, 1924, a resolution of the Board of Trustees of the Miami City Hospital was presented to the Miami City Commission at a called meeting. This resolution requested that the name of the hospital be changed from The Miami City Hospital to The James M. Jackson Memorial Hospital.[16] This resolution was unanimously adopted and the hospital carries his name down to the present.

Acknowledgment

The author wishes to acknowledge his appreciation of the help of many persons in collecting this information, chief among these was Mrs. Ethel Jackson Hutson, 1897-1964.

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▶ Dr. Straight, 550 Brickell Avenue, Miami 33131.

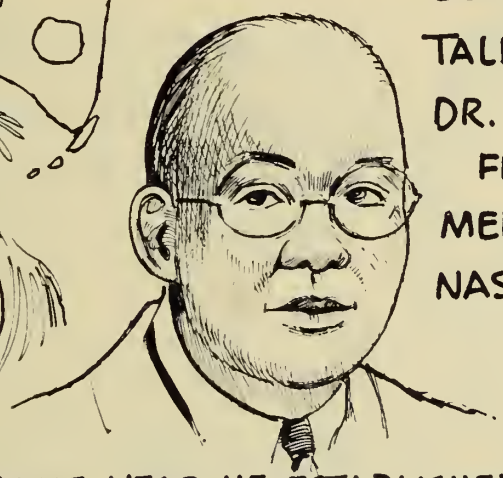
(To the right) The following two pages were reproduced by courtesy of the Florida Regional Medical Program and the artist, Mr. James Robe. Mr. Robe worked as a newspaper editorial cartoonist before joining the FRMP staff. For several years he published a weekly feature called "Highlights of Florida History" and when the FRMP Newsletter was established, it seemed only natural to develop the one on medical history. Several Florida physicians have assisted with suggestions and research to provide the background. The feature is brief but requires a good many hours of study before each is drawn. Mr. Robe would be happy to hear from other physicians with suggestions on medical personalities suitable for future drawings.

HIGHLIGHTS OF FLORIDA MEDICAL HISTORY

Dr. William Stevens

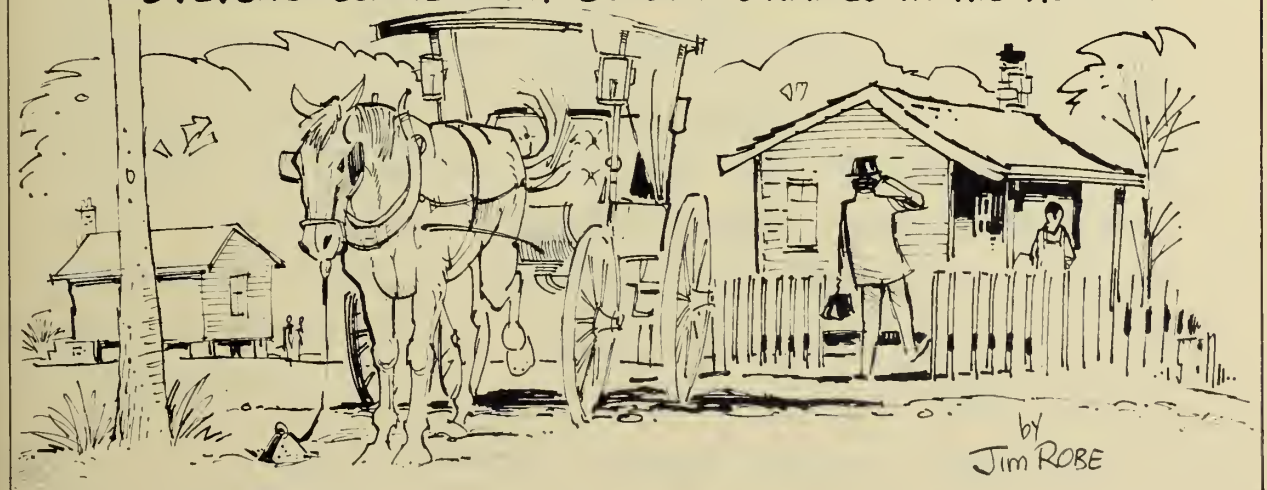
(1882 - 1949)





BORN AND RAISED IN TALLAHASSEE, FLORIDA, DR. STEVENS GRADUATED FROM MEHARRY MEDICAL COLLEGE, NASHVILLE, TENNESSEE IN 1904.

IN THE SAME YEAR HE ESTABLISHED AN OFFICE IN QUINCY. DURING THE YELLOW FEVER EPIDEMIC OF 1906 AND THE INFLUENZA EPIDEMIC OF 1917 HIS FAME SPREAD BECAUSE OF HIS SUCCESSFUL CURES. IN THE YEARS FOLLOWING DR. STEVENS ESTABLISHED A CLINIC, A HOSPITAL AND A DRUG STORE IN QUINCY. THE STEVEN'S ELEMENTARY SCHOOL IS NAMED IN HIS HONOR.



by Jim Robe

HIGHLIGHTS OF FLORIDA MEDICAL HISTORY

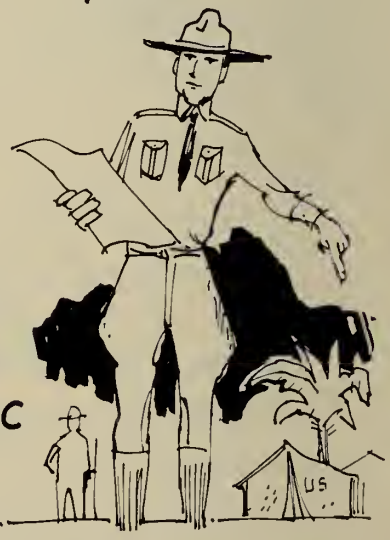
DR. HENRY HANSON

FLORIDA STATE HEALTH OFFICER 1929-1935 AND 1942-1945



DR. HANSON GRADUATED FROM JOHNS HOPKINS UNIVERSITY, SCHOOL OF MEDICINE IN 1908.

IN 1909 AT AGE 32, HE WAS NAMED DIRECTOR OF THE DIVISION OF BACTERIOLOGIC LABORATORIES.



HE DIRECTED FLORIDA'S HEALTH PROGRAM IN TWO SEPARATE TERMS, 1929-1935 AND 1942-1945. HE IS THE ONLY STATE HEALTH OFFICER TO BE SO HONORED. DR. HANSON DIED IN JACKSONVILLE IN 1954 AT THE AGE OF 76.

DURING WORLD WAR I IN THE ARMY MEDICAL CORPS, HE WORKED IN PANAMA AND PERU HELPING TO CONQUER THE DREAD YELLOW JACK!



BY JIM ROBE - FLORIDA REGIONAL MEDICAL PROGRAM -



Editorials

History of Medicine

The history of medicine is a study of man's health, not only as to the geographic and economic conditions of time and space that may have affected him and caused disease but also as to what the physician and society at any given time in history did to fight his disease and prevent its spread.

Medical history teaches us where we come from, where we are standing in our practice at the present time and in what direction we may march. If our work is not to be haphazard, but to follow an orderly plan, we need the guidance of history. It is not by accident that all medical leaders were fully aware of the value of historical studies. The history of medicine is more than an addendum to the history of science. The great central highway along which medical and scientific progress has moved is firmly based on probity of teaching and learning, integrity and professional conduct, service to society and the pursuit of knowledge. In spite of all its shortcomings, medical history is, in a sense, a history of civilization, the history of humanity itself with its ups and downs, its brave aspirations after truth and its pathetic failures. The subject may be treated variously as a pageant, an array of books, a procession of characters, a succession of theories, an exposition of human ineptitudes or as the very bone and marrow of cultural history.

In the continual remembrance of a glorious past, individuals and nations find their noblest inspiration. As no man can say who it was that first invented the use of clothes and houses against the inclemency of the weather, so also, can no investigator point out the origin of medicine. Mysterious as the source of the Nile, there has never been a time when it was not.

Again this year, we are indebted to Bill Straight and the contributing authors for their interesting addition to our heritage.

C.M.C.

What Does Non-Profit Mean?

The term "non-profit" means many things to many people. What does non-profit mean to Blue Shield subscribers? Are there advantages coming to Blue Shield subscribers due to the fact that Blue Shield is a non-profit corporation? The answer is an emphatic Yes.

We are frequently asked the question, "Does Blue Shield make a profit?" The answer is no if you define profit as Webster does as "the compensation accruing to entrepreneurs for the assumption of risk in business." On the other hand, the answer is yes in most years if you define profit as "excess of returns over expenditures." Such excess goes into Blue Shield reserves to insure its solvency in the interest of being able to continue serving subscribers. Blue Shield reserves average only about two months of its claim expenses. Blue Shield does not have to pay income taxes on such amounts because it is recognized by the Internal Revenue Service as a non-profit corporation.

How else is Blue Shield "profit" different from that of the profit of commercial insurance companies? The latter companies have stockholders who have invested in the company and are expected to make a profit in order that the stockholders will receive dividends on their investment.

Blue Shield must live under the insurance laws of the State of Florida; these laws provide that insurance companies must establish certain reserves in relation to the volume of business they do and benefits they provide to their subscribers. Since Blue Shield has no stockholders or other owners that receive dividends, they may use their "profits" to build up the legally required reserves and give the most in benefits to their subscribers for their premium dollar. I hope you have all read Dr. Zellner's article in the May, 1972 issue of the FMA Journal entitled, "Who Owns Blue Shield."

Blue Shield competes each day with private insurance companies for group coverage for health insurance benefits. Mr. Dan Pettengill, Vice President of Aetna Life and Casualty Company recently stated that over the last 15 years his Company had made only .54% on each premium dollar for group health insurance. The profit for dividends to pay their investor stockholders comes from selling life and casualty insurance. It is hard to believe that their profit margin would be so infinitesimal were they not competing with Blue Shield on a non-profit basis for group insurance coverage. Blue Shield of Florida not only benefits its 1,500,000 subscribers with lower premiums by being a non-profit corporation, but through competition helps provide lower premium coverage for hundreds of thousands covered by insurance companies for profit. I think this is wonderful.

Blue Shield of Florida is well worth the time and effort spent on it by the physicians of Florida, Blue Shield Board Members and the Committee of 17.

Charles K. Donegan, M.D.
St. Petersburg

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Medical News

Dermatology Society Elects Dr. Lewis

Leonard A. Lewis, M.D., Clinical Assistant Professor of Dermatology at the University of Miami School of Medicine, has been re-elected Secretary of the American Society of Dermatologic Surgery.

Six Mt. Sinai Physicians Honored

Six members of the Florida Medical Association have been named to the new category of Honorary Physician-Trustee of Mount Sinai Medical Center of Miami Beach.

Each of the six—Richard M. Fleming, M.D., Stanley Frehling, M.D., Solomon B. Goldman, M.D., Ralph E. Kirsch, M.D., Milton P. Travers, M.D., and Charles Werblow, M.D.—has been a member of Mount Sinai's medical staff for at least 20 years.

Mount Sinai's Executive Vice President, Samuel Gertner, said the Board of Trustees created the category of Honorary Physician-Trustee "in recognition of the vital contributions the medical profession can, and should, make in helping guide the policies, practices and growth" of the medical Center.

William J. Dean, M.D., of St. Petersburg, President of the Florida Medical Association, conducted the installation.

Dr. Papper Named to Foundation Board

Emanuel M. Papper, M.D., Dean of the University of Miami School of Medicine, has been elected to the Board of Directors of the London-based Royal Society of Medicine Foundation.

Dr. Maren Is Elected

Thomas H. Maren, M.D., of Gainesville, has been elected to a two-year term as President of the Association for Medical School Pharmacology.

The Association is composed of the chairmen of approximately 120 pharmacology departments in North America. Dr. Maren is Professor and Chairman of the Department of Pharmacology and Therapeutics at the University of Florida College of Medicine.

Clinical Center Study of Patients with Malignant Melanoma, Sarcoma of Soft Tissue or Bone

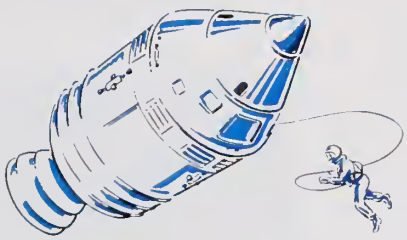
The cooperation of physicians is requested in the referral of patients with melanomas and sarcomas of soft tissue and bone for studies being conducted by the National Cancer Institute's Surgery Branch at the Clinical Center, National Institutes of Health, Bethesda, Maryland.

Needed are patients with primary tumors and those with limited mestastases which are amenable to primary surgical treatment. Selected patients will be admitted to combined surgery, chemotherapy, and immunotherapy protocols.

Patients treated will receive adjuvant therapy according to criteria based on tumor anatomic location and histologic type. Immunologic studies will be performed preoperatively and at intervals postoperatively to monitor the effects of adjuvant therapy and provide sensitive means of followup for earlier detection of recurrent tumor.

Upon completion of their studies, patients will be returned to the care of the referring physician who will receive a summary of findings.

Physicians interested in having their patients considered for admission to these studies may write or telephone: Alfred S. Ketcham, M.D., Clinical Center, Room 10-N-116, National Institutes of Health, Bethesda, Maryland 20014. Telephone: (301) 496-4164.



Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution a prophylaxis to prevent kidney or bladder calculi.

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NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, *300 mg.;* SODIUM ACID PHOSPHATE, *500 mg.*

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

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2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

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Blue Shield - UCR Program

Leo M. Wachtel, M.D.

In the beginning, "The Blue Shield principle of paid in full benefits for low income subscribers was. heralded as the doctor's plan. Yet, in the early stages especially, the most aggressive opposition, often accompanied by bitter recriminations, came from the medical profession. Primarily due to misunderstanding and misinformation, suspicion and mistrust abounded." The above quote is from "25 Years of Progress: A History of Blue Shield of Florida, 1946-1971."

Now, 26 years later, following public expression for a prepayment paid-in-full program without regard to income limits, there is a UCR (usual, customary, and reasonable) program which is also subject to some misunderstanding. This program was approved by the FMA House of Delegates in May, 1969, and was implemented by the Blue Shield Board in September 1969, to be a part of the Federal High Option Program. Subsequently, other groups who were willing to pay the price have purchased this coverage; however, these benefits had previously been in effect in Florida in certain national accounts covering a limited number of policy-holders for one or two years prior to that time.

The UCR Program is also being offered to selected Florida groups with 50 or more employees and most national accounts. Southern Bell and Western Electric contracts cover 80% of UCR charges. The UCR type of coverage is most in demand by both union and management insurance negotiators. This is the kind of coverage the medical profession has been attempting to have the Industrial Commission provide under Workmen's Compensation.

The only fee schedule in the UCR Program is the one each doctor sets for himself—his usual fee for a service, set by his charges for the service in the preceding year. The fee allowance profile for each participating physician was updated to be effective April 1972. If, by chance, a physician's charges are higher than the customary charges in his area, only the customary charge would be payable unless explanation of unusual circumstances justified his unusual fee as reasonable, considering those "unusual circumstances." Over 20 million charges of Florida physicians during a period of two and one-half years was tabulated by Blue Shield to establish, originally, customary charges, and the ranges of allowed fees has been updated annually.

Under the UCR Program, fees falling within the 90th percentile are paid, and this has covered in full between 90% to 95% of all claims filed. Much confusion exists in the minds of many Florida physicians because the Medicare program pays on the 50th percentile of the individual physician's fee and the 75th percentile of the area fee for a given service. The difference between the UCR Program allowances and Medicare Program allowances must be distinguished.

The UCR type of insurance coverage was developed to meet the needs and desires of the public, our patients, often with union-management negotiation and the blessings of organized medicine. It constitutes at this time the best argument against further government interference in the doctor-patient relationship and the unfettered practice of private physicians. If we won't participate, less palatable methods of payment will be forced on us by political hacks.

▸ Dr. Wachtel, 2708 St. Johns Avenue, Jacksonville 32205.

Woman's Auxiliary

A REVIEW

IT WAS A VERY GOOD YEAR!!! This is not a commentary on vintage wine or the national economy. It refers to the accomplishments of your Woman's Auxiliary.

"Community Concern" was the theme and "Let's Make Waves" was the slogan.

The county auxiliaries met the challenge in a variety of ways—benefits for medical and nursing scholarships and increasing loans. Food and clothing was provided for needy families. Special parties were planned for inmates of nursing homes, orphanages and for crippled children and adults. Many worked with local Heart, Cancer and Mental Health Associations, Red Cross Chapters, Public Health Departments and County School Boards. One county is purchasing a Linear Accelerator for their County Hospital. Another, which had purchased a Phono-Cardio Scan last year, followed through in putting it to use in the public schools. A project involving a great number of members and their husbands was the raising of funds to establish a Health and Science Exhibit at the Children's Museum in their city. Many volunteer hours were devoted to assisting in drug and migrant clinics. Do you recognize the project of your own county auxiliary? If not, do hope you will check it out. You will be amazed with the work they have done.

Membership had top priority again this year. We had a substantial increase, but there is still a large gap between the number of medical and auxiliary members in both the state and county. We need your help to close this gap. At the beginning of the year, a plea was made for each of you to encourage your wife to at least become a "dues paying" member. We realize that many of them, for legitimate reasons, can not take an active part in her group, but her dues swells the working capital for instituting and developing the programs which have been requested by you.

Our legislative activities took many hours of planning and hard work. Our state chairman, Ruby (Mrs. Maurice) Hodge and Bennie (Mrs. Arnold J.) Spanjers, our representative to your FLAMPAC Board with their district and county chairmen, "got it all together." Educating our women to their responsibility and "how to" become most effective was our goal. The increase in FLAMPAC membership and our method of utilizing the many available sources of information, cooperating with your legislative committees and personnel and communicating with the counties (where action really counts), has been commended by the National FLAMPAC and Legislative Chairmen.

Speaking of recognition, with the prodding of our state chairman, Libby (Mrs. William L.) Read, our contributions to AMA-ERF earned us the Regional Merit Award at the Woman's Auxiliary to the AMA annual meeting. This is an example of what can be done when we join forces. One auxiliary, Pinellas, donated over $5,000. Hillsborough, Sarasota and Broward were not far behind. Manatee county had the largest per capita

donation for the state. Their $28 was more than double our aim of $10 per member.

Attendance at our Health Careers Clubs' Annual Meeting in April was just under the 400 of last year. Our Health Careers chairman, Lynn (Mrs. Terry F.) Tanner was still pleased, because in spite of "split-sessions," and in some instances, lack of cooperation by school personnel, 66 Health Career Clubs were sponsored by our auxiliaries. You would have been proud of the young people at the meeting. There was no riot, sit-in or demonstration, just well planned sessions, outstanding speakers and well behaved ladies and gentlemen (we have been invited back by the hotel), so, of course, there was very little notice by the news media, but that won't keep the dedicated wives of many of you from working even harder to recruit these young people to join your health care team.

Marion (Mrs. C. H.) Gilliland, National Regional Chairman of the International Health Activities committee can hold her head high with Florida's report of $1,279.06, raised at the annual IHA Bazaar of our Fall Conference.

Our account in the Florida Medical Foundation, which is used to aid destitute physicians and their families, was increased by just under a $1,000. The money was raised through the sale of Sea Food and Citrus Fruit, the profits from the Oriental Tour and individual donations.

The Drug Abuse Education program under the leadership of Bennie Spanjers, who is a member of the FMA's Ad Hoc Committee on Drug Abuse, has been expanded. She has worked closely with the State Department of Education and has appointed key women in each county to act as her liaison.

This is a limited review of the many activities. We have tried to fulfill the requests made by your Board of Governors. As you can see the emphasis is on the accomplishments at the county level. Your cooperation, interest and encouragement is very important to us.

Keep watching this space. Catherine DeVito (Mrs. James J.), from St. Augustine, our current president will be reporting to you. She is tiny, but mighty. Her enthusiasm, leadership abilities and background of work on the state level has won our love and know you will enjoy working with her for another VERY GOOD YEAR.

Barbara Nock (Mrs. Wesley S.)
Immediate Past President
Miami

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Miami-based corporation, with sales in excess of a billion dollars, seeks to expand its medical staff with the addition of either a part-time (20 hrs./wk) or full-time physician. The individual selected for this opening would be expected to handle the clinical aspects of our dynamic industrial health program. Florida license required.

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Warnings: Use during pregnancy is to be avoided.
Precautions: 1. *Starvation Ketosis:* This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria which, in spite of relatively normal blood and urine sugar, may result from excessive phenformin therapy, excessive insulin reduction, or insufficient carbohydrate intake. Adjust insulin dosage, lower phenformin dosage, or supply carbohydrates to alleviate this state. **Do not give insulin without first checking blood and urine sugar.**
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Usual dosage: one 50-mg. capsule with breakfast may be effective, or a second capsule may be given with the evening meal.

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phenformin HCl

MEETINGS

Approved by FMA Committee on Continuing Education

AUGUST

17-19 Postgraduate Obstetric-Pediatric Seminar, Pier 66 Hotel, Fort Lauderdale. For information: A. F. Caraway, M.D., Box 210, Jacksonville 32201.

SEPTEMBER

4- 9 Course of Instruction in Coronary Care for the Practicing Physician, Jackson Memorial Hospital, Miami. For information: Louis Lemberg, M.D., U. of Miami School of Medicine, Box 875, Biscayne Annex, Miami 33152.

14-16 Medical Care Problems in the Surgical Patient, Mount Sinai Hospital, Miami Beach, For information: Frances Richardson, 4300 Alton Road, Miami Beach 33140.

21-24 Emergency Medical Systems—National Symposiums, by University of Florida College of Medicine, Contemporary Hotel, Disneyland at Orlando. For information: Lamar Crevasse, M.D., Box 758, J. Hillis-Miller Health Center, Gainesville 32601.

OCTOBER

16-20 Current Problems in the Therapy of Patients with Coronary Artery Disease, Mount Sinai Hospital, Miami Beach. For information: Frances Richardson, 4300 Alton Road, Miami Beach 33140.

16-21 Course of Instruction in Coronary Care for the Practicing Physician, Jackson Memorial Hospital, Miami. For information: Louis Lemberg, M.D., U. of Miami School of Medicine, Box 875, Biscayne Annex, Miami 33152.

NOVEMBER

3 Lymphoma-Leukemia for Physicians, Manger Hotel, Tampa. For information: John Carbonneau, 1001 S. MacDill Ave., Tampa 33609.

DECEMBER

8-10 "The Spinal Cord Injured Patient," from the Department of Orthopaedics and Rehabilitation, University of Miami School of Medicine, Americana Hotel, Miami Beach. For information: Augusto Sarmiento, M.D., Box 875, Biscayne Annex, Miami 33152.

National and Regional Meetings Held in Florida

NOVEMBER

2- 4 International Conference on Trichinellosis, Sheraton-Four Ambassadors Hotel, Miami. Sec.: W. C. Campbell, Ph.D., Merck Institute, Rahway, N. J. 07065.

2- 6 Association of American Medical Colleges, Fontainebleau Hotel, Miami Beach. Pres.: John A. D. Cooper, M.D., 1 Dupont Circle, Washington, D. C. 20036.

6-10 American Society of Tropical Medicine and Hygiene, Deauville Hotel, Miami Beach. Sec.-Treas.: George R. Healy, Ph.D., P.O. Box 15208, Emory University Branch, Atlanta, Ga. 30333.

19-22 Pan American Medical Association, Deauville Hotel, Miami Beach. Dir. Gen.: Joseph J. Eller, M.D., 745 5th Avenue, New York 10022.

DECEMBER

1- 2 American College of Chemosurgery, Balmoral Hotel, Miami, Sec.-Treas.: Richard S. Moraites, M.D., 7721 Montgomery Rd., Cincinnati, Ohio 45236.

2- 7 American Academy of Dermatology, Americana Hotel, Miami Beach. Sec.-Treas.: Frederick A. J. Kingery, M.D., 2250 Northwest Flanders Street, Portland, Oregon 97210.

3- 6 American Society of Hematology, Diplomat Hotel, Miami Beach. Sec.: Steven Robinson, M.D., Beth Israel Hospital, 330 Brookline Avenue, Boston 02215.

4- 6 Southern Surgical Association, Boca Raton Hotel, Boca Raton, Sec.: David C. Sabiston Jr., M.D., Duke University Medical Center, Durham, N.C. 27710.

1973

MAY

21-24 American College of Obstetricians and Gynecologists, Americana Hotel, Miami Beach. Dir.: Michael Newton, M.D., 79 West Monroe Street, Chicago 60603.

JUNE

11-15 Society of Nuclear Medicine, Americana Hotel, Miami Beach. Exec. Dir.: Mrs. Margaret Glos, 211 East 43rd Street, New York 10017.



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Description: CANDEPTIN (candicidin) Vaginal Ointment contains a dispersion of candicidin powder equivalent to 0.6 mg. per gm. or 0.06% Candicidin activity in U.S.P. petrolatum. 3 mg. of Candicidin is contained in 5 gm. of ointment or one applicatorful. CANDEPTIN Vaginal Tablets contain Candicidin powder equivalent to 3 mg. (0.3%) Candicidin activity dispersed in starch, lactose and magnesium stearate. CANDEPTIN VAGELETTES Vaginal Capsules contain 3 mg. of Candicidin activity dispersed in 5 gm. U.S.P. petrolatum.
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Indications: Vaginitis due to Candida albicans and other Candida species.
Contraindications: Contraindicated for patients known to be sensitive to any of its components. During pregnancy manual Tablet or VAGELETTES Capsule insertion may be preferred since the use of the ointment applicator or tablet inserter may be contraindicated.
Caution: During treatment it is recommended that the patient refrain from sexual intercourse or the husband wear a condom to avoid re-infection.
Adverse Reaction: Clinical reports of sensitization or temporary irritation with CANDEPTIN Vaginal Ointment, Vaginal Tablets or VAGELETTES Vaginal Capsules have been extremely rare.
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Store under refrigeration to insure full potency.

Federal law prohibits dispensing without prescription.

References: **1.** Olsen, J.R.: Journal-Lancet *85* 287 (July) 1965. **2.** Giorlando, S.W.: Ob/Gyn Dig. *13*:32 (Sept.) 1971. **3.** Decker, A.: Case Reports on File, Medical Department Julius Schmid. **4.** Giorlando, S.W., Torres, J.F., and Muscillo, G.: Am. J. Obst. & Gynec. *90*: 370 (Oct. 1) 1964. **5.** Lechevalier, H.: Antibiotics Annual 1959-1960. New York, Antibiotica Inc., 1960. pp. 614-618. **6.** Friedel, H.J.: Maryland M.J., *15*:36 (Feb.) 1966.

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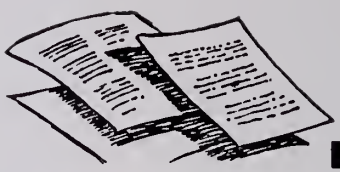
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Letters

Dear Editor:

The response of the Florida Medical Association members to the Florida Special Olympics program has been simply sensational.

The current list of area coordinators and the Medical Advisory Committee will verify this as all members contacted on the list have accepted the appointment.

Speaking for the Executive Committee of the Florida Special Olympics, let me say thanks again for all of the Florida Medical Association's support.

T. Norley, M.D.
West Palm Beach

Dear Editor:

I was most gratified by the response of my colleagues locally to the several poems of mine that you published recently. At their urging, I am submitting a few more for your consideration.

Would you consider reprinting some poems of general medical interest that have appeared previously in other periodicals? Perhaps you could establish a Poet's Corner in the Journal that would encourage submission of verses and aphorisms from a variety of medical people.

My experience is that there are quite a number of talented and artistically creative individuals in our profession who would welcome such an opportunity to display their wares.

A. L. Lieber, M.D.
Miami Beach

Dear Editor:

On page 23 of the June issue of the Journal, Dr. Carithers reports that "the World Health Organization has agreed on an official description of a doctor."

The description given is that of a physician! Patients, friends and the general public may call us "Doctor," but, please, when it comes to matters of definition, let us be physicians.

David A. Cofrin, M.D.
Gainesville

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Deaths

Adair, Fred L., Maitland; born 1877; Rush Medical College, 1901; member AMA; died February 13, 1972.

Bransford, Lee E. Sr.,, Jacksonville; born 1886; Baltimore Medical College, 1910; member AMA; died May 1, 1972.

Brown, Harry W., St. Petersburg; Born 1920; Tufts University, 1950; member AMA; died April 27, 1972.

Cawthon, William D., DeFuniak Springs; born 1890; Georgia Medical School, 1914; member AMA; died January 16, 1972.

Cunningham, Charles B., St. Petersburg; born 1908; University of Michigan, 1934; member AMA; died April 15, 1972.

Dame, LeLand H., Winter Park; born 1887; Emory University, 1917; member AMA; died June 15, 1972.

Davis, Kenneth M., Delray Beach; born 1892; Emory University, 1914; member AMA; died February 23, 1972.

Diehl, Earl H., Plant City; born 1909; University of Maryland, 1935; member AMA; died March 9, 1972.

Eyster, William H. Jr., Ormond Beach, born 1917; University of Pennsylvania, 1943; member AMA; died April 8, 1972.

Gwynn, Humphrey W., Orlando; born 1891; University of Maryland, 1916; member AMA; died January 20, 1972.

Hotard, Roland F. Sr., Winter Park; born 1893; Tulane University, 1915; member AMA; died April 24, 1972.

Judd, Robert C., North Palm Beach; born 1922; Loma Linda University, 1954; member AMA; died March 24, 1972.

Langston, Henry I., Fort Walton Beach; born 1920; Tulane University, 1946; member AMA; died March 15, 1972.

Levine, Sanford, Miami Beach; born 1912; Louisville Medical School, 1939; member AMA; died February 9, 1972.

Marshall, Otis, St. Augustine; born 1884; University of Virginia, 1907; member AMA; died—date unknown.

McCorkle, Albert W., Hialeah; born 1913; Loma Linda University, 1950; member AMA; died February 1, 1972.

McGehee, Nat T. Jr., Hollywood; born 1923; Georgetown University, 1953; member AMA; died January 26, 1972.

McLemore, Carl S., Orlando; born 1907; Washington University St. Louis, 1933; member AMA; died May 18, 1972.

Moeller, Maximilian W., St. Petersburg; born 1890; Marquette Medical School, 1913; member AMA; died February 20, 1972.

Neuwirth, Abraham A., Tampa; born 1906; Bellevue Medical School, 1930; member AMA; died February 23, 1972.

Newquist, Melvin N., Clearwater; born 1897; University of Nebraska, 1924; member AMA; died March 7, 1972.

Payne, Walter C. Sr., Pensacola; born 1889; Tulane University, 1912; member AMA; died May 3, 1972.

Renwick, John A., Coral Gables; born 1890; University of West Ontario, 1917; member AMA; died January 25, 1972.

Rogers, Wieland W., Jacksonville; born 1901; Vanderbilt University, 1927; member AMA; died April 29, 1972.

Scott, Douglas G., Atlantic Beach; born 1903; Northwestern University, 1930; member AMA; died May 16, 1972.

Sapulding, Earl M., Pensacola; born 1916; University of Louisville, 1940; member AMA; died January 3, 1972.

Tolle, Robert L., Orlando; born 1907; Washington University, 1935; member AMA; died January 28, 1972.

Watson, John E., MacClenny; born 1906; University of Arkansas, 1943; member AMA; died March 19, 1972.

West, John R., Daytona Beach; born 1909; University of Buffalo, 1937; member AMA; died March 13, 1972.

Wrenn, Simeon M., Winter Park; born 1896; South Carolina Medical School, 1930; member AMA; died March 9, 1972.

DEATH

Life starts with a flourish
Marches boldly forth
Then totters and falls
To become a new beginning
Through those who seek knowledge
with which to secure it . . .
HIC EST UBI MORS GAUDET SUCCURERE VITAE.

A. L. Lieber, M.D.
Miami Beach

Art Yes, Science Yes

Apocryphal stories are all about wonderful things that never happened, but I'll take them over timeworn cliches any day. Like where there's smoke there's fire and the one about too many cooks; and especially *medicine's not a science, it's an art.* Maybe some of the art was sincere and beneficial, but one is apt to recall the art in the artful dodger when this kind of art covers a thin veneer of science, like a mouthwatering gravy on a poor roast.

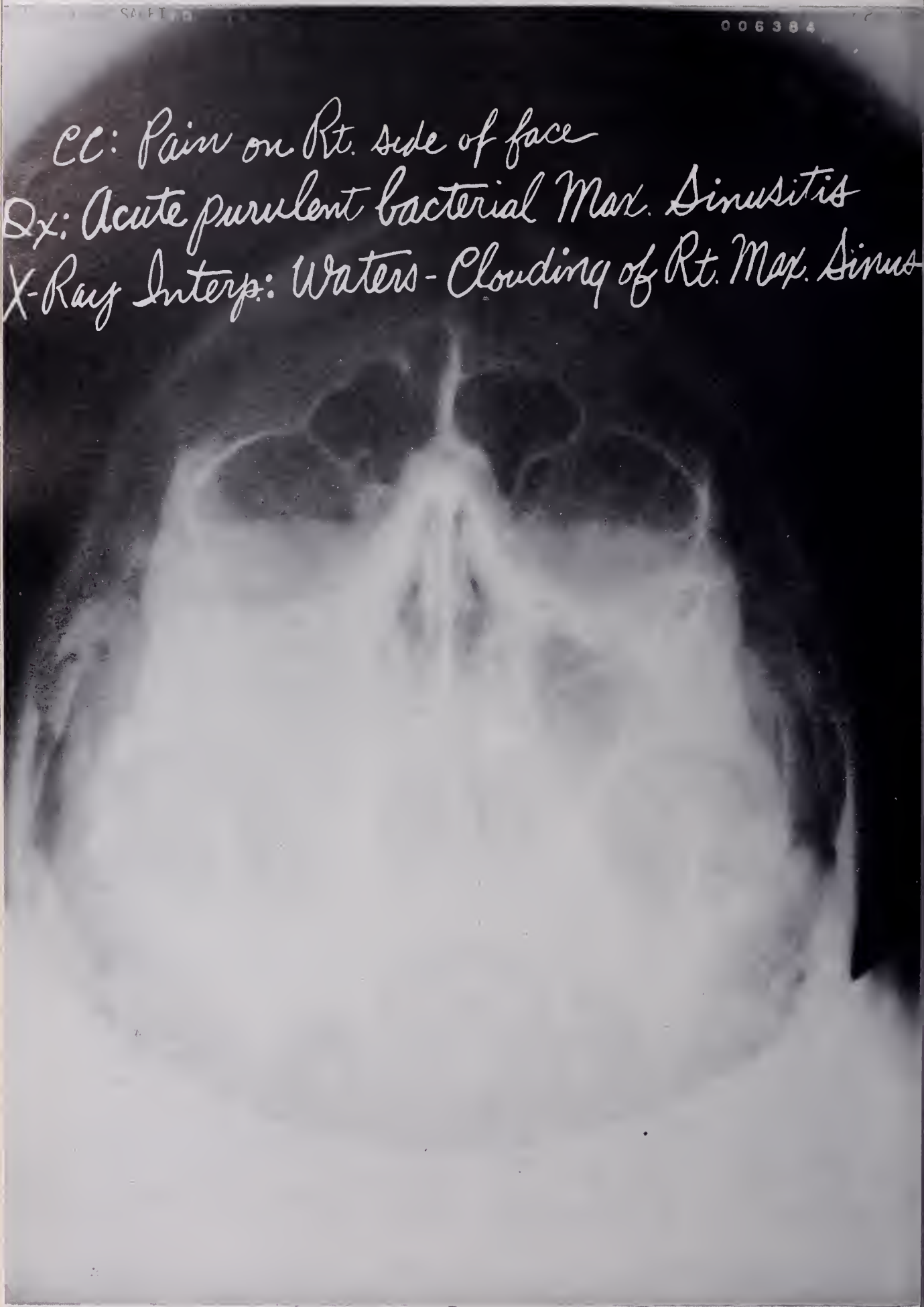
Architects cover their mistakes with ivy, cooks with mayonnaise, and lawyers with whereases. And with our very own cliche, we may conceal uncertainty with something that may or may not be art. A genuine feeling for the patient associated with confidence and respect is the backbone of our profession, but we may not fall back, when our predictions go astray, on the old saw about medicine being an art, not a science.

Medicine *is* a science, and its art consists in compassion and integrity. The human body is scientific, and if it is we who are not, let us not take refuge in words. To tell a patient things are going well when we do not know is a debatable kind of art. And as the past quarter of a century has bombarded us with knowledge, how much better it is to *know.* Perhaps it was good, in the past, to take the worries from the patient and from his kin when we were ourselves unsure, like Fildes' doctor. But if medical articles are no longer easy to read, for want of mathematical skill, it is good.

For we had much to learn, and we know more now. Let medicine be an art, compounded of sincerity and love. But it is, above all, a science.

Frank Cole, M.D., Editor
Nebraska Medical Journal

Reprinted from the February, 1972, Nebraska Medical Journal.



X-ray provided by Manhattan Eye, Ear and Throat Hospital

Hackie Hemorrhoids

Mr. H. C., 40, taxicab driver, married with four children. Complains of anorectal pain, itching and irritation. Works long hours often in extreme heat in non-air conditioned cab. Sweats a great deal. Sudden perianal swelling two days ago. Similar episode when he was 24 years old. Examination reveals large prolapsing edematous internal and external hemorrhoids.



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Indications: Acute, recurrent or chronic urinary tract infections (primarily cystitis, pyelitis, pyelonephritis) due to susceptible organisms (usually *E. coli, Klebsiella, Aerobacter, Staphylococcus aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies.

IMPORTANT NOTE: *In vitro* sulfonamide sensitivity tests are not always reliable. The test must be carefully coordinated with bacteriologic and clinical response. When the patient is already taking sulfonamides, follow-up cultures should have aminobenzoic acid added to the culture medium.

Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of antibacterial agents including the sulfonamides, especially in the treatment of chronic and recurrent urinary tract infections.

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Warnings: Safety of sulfonamides in *pregnancy* has not been established. Sulfonamides will not eradicate group A streptococci. Deaths associated with sulfonamide administration have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts and urinalyses with careful microscopic examination should be performed frequently during sulfonamide therapy.

Precautions: Use with caution when impaired renal or hepatic function, severe allergy or bronchial asthma is present. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis (frequently a dose-related reaction) may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia, methemoglobinemia. *Allergic reactions:* Erythema multiforme (Stevens-Johnson syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia, allergic myocarditis. *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis, stomatitis. *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria. Periarteritis nodosa and L.E. phenomenon have occurred with sulfonamide therapy. Sulfonamides bear certain chemical similarities to some goitrogens, diuretics and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents.

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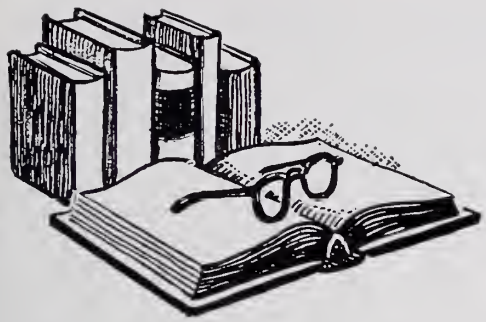
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Book Reviews

Teeth, Teeth, Teeth by Sydney Garfield, M.D. Pp. 448. Illustrated. Price $9.95. New York, Simon & Schuster, 1969.

Teeth, Teeth, Teeth by Sydney Garfield presents a highly technical subject in a manner which makes the book as hard to put down as was The Godfather. Human interest stories and humor are used throughout for illustration. It is recommended reading for almost everyone and a necessity for anyone in the healing arts.

Here, in a mere 450 pages, is a four year dental education in condensed form. It is a rare individual who can fully master all the disciplines of a profession and it is even more rare to be able to skillfully write about a technical subject. Dr. Garfield obviously is this individual.

This work is a great contribution in that to read it is to gain a better understanding and appreciation for the lower third of the only appendage our body cannot get along without.

Joel W. Baker, D.D.S.
Jacksonville

Unfortunately, many physicians ignore or disregard their patient's dental problems but they very often can contribute immeasurably to the patient's general health and wellbeing. Sometimes there is a mirror of a general disease process in the study of the teeth and gums which can give a definite clue to the presence of disease. In addition, Teeth, Teeth, Teeth is a treatise which can be highly recommended for school and public libraries.

Floyd K. Hurt, M.D.
Jacksonville

Handbook of Poisoning by Robert H. Dreisbach, M.D., Ph.D. Pp. 515. Illustrated. Price $6.00. Los Altos, California, Lange Medical Publications, 1971.

This excellent soft bound volume is the 7th edition attesting to its merit. The contents encompass considerably more material than is normally thought of as "poisoning." This well organized book covers such subjects as industrial hazards, cosmetic risks, food poisoning, animal and plant toxicity, together with medicinal and agricultural poisons, prevention, clinical findings, treatment, prognosis, methods of identification and a list of sources where antidotes may be obtained rapidly. The book is specific in its recommendations and pointed in it observations and is a valuable supplement to the material found in Poison Control Centers. The size of it makes it handy enough to be carried in a medical bag.

Courtlandt D. Berry, M.D.
Naples

American Medicine and the Public Interest by Rosemary Stevens. Pp. 575. Price $18.50. Yale University Press, 1971.

This is one of the most important books on the history of the development of the medical profession in the U.S. It is a scholarly effort, well researched and documented, though lopsided in its point of view. As a historical book, it will become a classic because of the massive amount of research required to produce it. Professor Stevens says the Journal of the AMA "was read from 1930 to 1970" as well as other periodicals such as the Journal of Medical Education. She acknowledges help from Dr. Paul Sanazaro of the Association of American Medical Colleges and Dr. John Nunemaker from the AMA Council on Medical Education as well as many others in the specialty organizations.

Mrs. Stevens is associate professor of Public Health at Yale. This is the second of a three volume work. Her previous book was entitled *Medical Practice in Modern England; The Impact of Specialization and State Medicine.* The third projected volume is to deal with comparative aspects of health care organization in the U.S. and England.

The chapters dealing with development of medical specialization are informative. She describes, somewhat cynically I feel, how surgery emerged as a specialty which was glamorous and which would command large fees. This would differentiate the surgeons from other medical practitioners. She also ascribes the development of the

surgical specialties in part to the influence of the Mayo Clinic, begun by two surgeons. Also, the abortive attempt in 1957 to organize the American Board of Abdominal Surgery was interesting. This never came off but the American Society of Abdominal Surgeons is described as having 9,000 members in 1967. ". . . here the matter rests: a threat to the fabric of the specialty boards, and a continued question mark as to future regulation of surgery. . . . Somehow the scientific, professional and social elements inherent in specialty demarcations needed to be synchronized."

The decades of the thirties through the fifties are described as years of ferment and change as the medical profession changed from one of predominantly general practitioners to one of specialists. The specialty organizations and boards are pictured as sequestering to themselves areas of special interest both anatomically and financially. In this era, she describes the AMA as becoming weaker and more disorganized.

Then as the 60's came on and with the impact of government on the delivery of health care, the AMA emerged stronger and more unified as the spokesman for nearly all the medical profession. She describes the AMA as disorganized and archaic on the one hand and gigantically powerful on the other.

The last chapter on the public interest seems anemic and falls short of my expectations. While most of the book is related to the historical development of the medical profession, I felt that she could have given more detailed projections for the outcome of health care in the U.S. She predicts that the hospital will emerge in importance in the delivery of health care. (We could have predicted that.) ". . . no national health insurance scheme or local health service system can work effectively without effective organization of the medical profession. . . . Even under the most sweeping form of national health insurance, organized physician groups acting as governmental agents would become more powerful rather than less." "At the state and local level, the peer review movement may be expected to continue."

Even though the book has limitations and I believe is biased against the private practice of medicine as we feel it should be practiced, it is informative and reliable. It will become, I predict, a classic in the area of development of the medical profession as it affects health care in the U.S.

F. Norman Vickers, M.D.
Pensacola

Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

Cardiovascular Physiology, Second Edition, by Robert M. Berne, M.D. and Matthew N. Levy, M.D. Pp 265. 193 Illustrations. Price $9.25. St. Louis, The C. V. Mosby Company, 1972.

The Pediatric Nurse Practitioner by Fernando J. deCastro, M.D. and Ursula T. Rolfe, B.A., M.D. Pp. 154. Illustrated. Price $6.50. St. Louis, The C. V. Mosby Company, 1972.

A Primer of Electrocardiography by George E. Burch, M.D. and Travis Winsor, M.D. Pp. 292. 287 Illustrations. Price $7.75. Philadelphia, Lea & Febiger, 1972.

Hematopoietic and Gastrointestinal Investigations with Radionuclides by Albert J. Gilson, M.D., William M. Smoak III, M.D. and Morton B. Weinstein, M.D. Pp. 456. Illustrated. Price $30. Springfield, Ill., Charles C. Thomas, Publisher, 1972.

Cancer Diagnosis in Children by L. D. Samuels, M.D. Pp. 131. Illustrated. Price $25. Cleveland, Ohio, CRC Press, 1972.

Advances in Forensic and Clinical Toxicology by A. S. Curry. Pp. 280. Illustrated. Price $32.50. Cleveland, Ohio, CRC Press, 1972.

The Chinese Art of Healing by Stephan Palos. Pp. 237. 50 Illustrations. Price $1.50. New York, Bantam Books, Inc., 1972.

The Care of Minor Hand Injuries by Adrian E. Flatt, M.D. Pp. 293. 323 Illustrations. Price $21.50. St. Louis, The C. V. Mosby Company, 1972.

A Civilian Doctor in Vietnam by Fred Gloeckner, M.D. Pp. 123. 27 Illustrations. Price $5. Philadelphia, Pa., The Winchell Company, 1972.

Introduction to Neuroscience, Edited by Jeff Minckler, M.D., Ph.D. Pp. 420. 661 Illustrations. Price $22.50. St. Louis, The C. V. Mosby Company, 1972.

Review of Medical Microbiology by Ernest Jawetz, M.D., Ph.D.; Joseph L. Melnick, Ph.D.; Edward A. Adelberg, Ph.D. Pp. 518. Illustrated. Price $8.00. Los Altos, Calif., Lange Medical Publications, 1972.

General Urology by Donald R. Smith, M.D. Pp. 436. Illustrated. Price $8.50. Los Altos, Calif., Lange Medical Publications, 1972.

Mental Health Training and Public Health Manpower by Stephen E. Goldston, Ed. D., M.S.P.H. and Elena Padilla, Ph.D. Pp. 294. Price $2.75. Rockville, Maryland, National Institute of Mental Health, 1971.

Florida Organizations of Medical Interest
Meetings and Officers

Organization	President	Secretary	Annual Meeting
rida Medical Association	William J. Dean, St. Petersburg	James W. Walker, Jacksonville	Bal Harbour, May 9-13, 1973
Florida Specialty Societies			
ergy Society, Fla.	Bernard M. Barrett, Pensacola	Angelo P. Spoto Jr., Lakeland	
esthesiologist, Society of	Norman J. Gengler, Sarasota	George T. Edwards, Ft. Lauderdale	
est Phys., Fla. Chap., Am. Coll.	Lawrence C. Manni, Jacksonville	Eugene J. Sayfie, Miami	
rmatology, Society of	Tobias R. Funt, Ft. Lauderdale	Hillard J. Halpryn, Hialeah	
ergency Phys., Fla. Chap., Am. Coll.	William C. Douglass, Sarasota	Martin E. Amundson, Sarasota	
mily Physicians, Fla. Academy of	Edward W. Stoner, Oviedo	Joseph P. Hendrix, Port St. Joe	
stroenterologic Society	John M. Rumball, St. Petersburg	James L. Borland Jr., Jacksonville	
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urology, Fla. Society of	Richard L. Parker Jr., Winter Park	Jacob Green, Jacksonville	
urosurgical Society, Fla.	Albert J. Ehlert, Coral Gables	Robert S. Tolmach, Miami	
st. & Gynec. Society	Charles A. Johnson Jr., Clearwater	Henry L. Wright, Tampa	
hthalmology, Fla. Society of	G. Brock Magruder, Orlando	Alfred G. Smith II, South Miami	
hopedic Society, Fla.	Baxter L. Clement, Ft. Lauderdale	Walter C. Jones III, Coral Gables	
olaryngology, Fla. Society of	John W. Stone, Lakeland	Fredric W. Pullen II, Miami	
hologists, Fla. Society of	Sanford A. Mullen, Jacksonville	Matthew C. Patterson, Jacksonville	
liatric Society, Fla. Chap. of Am. Academy of Pediatrics	James M. Stem, Clearwater	James M. San, Tampa	
liatric Surgeons, Fla. Assn. of	H. Warner Webb, Jacksonville	James L. Talbert, Gainesville	
ys. Med. & Rehab., Fla. Society of	George A. Cunningham III, Palm Beach	Frank W. Moreau, Sarasota	
stic & Reconstr. Surgery, Fla. Society of	Alvaro Alfonso, West Palm Beach	Harold Norman, Miami	
ventive Medicine, Fla. Society of	James J. Hutson, Miami	R. Chris Brown, Largo	
ctologic Society, Fla.	Thomas S. Gowin, Coral Gables	Manuel L. Carbonell, Miami	
chiatric Society, Fla.	Robert L. Williams, Gainesville	Merton L. Ekwall, Tallahassee	
diological Society, Fla.	William F. Lindsey, Tallahassee	Ralph C. Aye, Tampa	
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geons, Fla. Surgical Div., nt. Coll.			
geons, Thoracic, Fla., ociety of	John P. Collins, Lakeland	Thomas M. McNeill, Orlando	
logical Society, Fla.	Clark A. Whitehorn, Panama City	John R. Browning, Jacksonville	
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erican Cancer Society	Mr. Myron Gibbons, Tampa	Mrs. Ruth Fillingim, Pensacola	Daytona Beach, Oct. 27-29, 1972
hritis Foundation	Mr. Sam Lewis, Hollywood	Mr. Ted K. Grahn, Bradenton	Tampa, May 1973
e Shield of Florida, Inc.	Mr. J. W. Herbert, Jacksonville	Mr. J. S. Slye, Jacksonville	Miami Beach, May 9-13, 1973
rd of Medical Examiners	Vernon B. Astler, M.D., Boynton Beach	C. C. Mendoza, M.D., Jacksonville	Tampa, Jan. 28-30, 1973
ppled Children & Adults	W. J. Hutchinson, M.D., Tallahassee	Mr. M. R. Adkins, Miami	Disney World, Oct. 13-14, '72
rida Industrial Medical Assn.	S. Victor Kassels, M.D., Tampa	J. A. Baird, M.D., Bradley	Miami Beach, Oct. 13-14, '72
rida Heart Association	Robert E. Windom, M.D., Sarasota	Mr. W. W. Hasenzahl, Ocala	Sarasota, May 25-27, 1973
rida Kidney Foundation	Mr. Clay Morgan, Gainesville	Miss Pamela Edwards, Tampa	October 1972
kemia Society of America	Mr. I. S. Whitman, Miami	Mr. Murray Dronsky, Miami	(Undecided)
ntal Health Association	Mr. W. H. Chubb, Winter Park	Mr. C. H. Cahill, Maitland	Orlando, October 1972
ional Foundation	(Not available)		
ional Multiple Sclerosis	(Not available)		
vention of Blindness	Mr. P. R. Bowman Sr., Orlando	Miss Doris McCullough, Tampa	Jacksonville, January 1973
arded Children Assn.	Mr. J. G. May Jr., Tallahassee	Mr. T. W. Hook, Lakeland	Tampa, Sept. 14-16, '72
berculosis & Res. Dis. Assn.	Mr. C. W. Lantz, Hollywood	Mr. R. R. Bohn, Jacksonville	Key Biscayne, April 26-28, 1973
ted Cerebral Palsy	Mr. T. G. Freeman, Sanford	Mr. Anthony Noboa, Miami	(Undecided)
man's Auxiliary to FMA	Mrs. J. J. DeVito, St. Augustine	Mrs. G. T. Singleton, Gainesville	Miami Beach, May 9-13, 1973

(Most Specialty Group meetings are scheduled at the time of the annual meeting of the Association)

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1972-1973

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VOL. 59, NO. 9
SEPTEMBER 1972

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To live content with
small means; to seek
elegance rather than
luxury, and refinement
rather than fashion;
To be worthy,
not respectable,
and wealthy, not rich;
to study hard,
think quietly,
talk gently,
act frankly;
to listen to stars and birds,
to babes and sages
with open heart;
to bear all
cheerfully,
do all bravely,
await occasions,
hurry never.
In a word,
to let the spiritual,
unbidden and unconscious,
grow up through the common.
This is to be my symphony.

W.E. Channing
1818-1901


The negative power of clinically significant anxiet
in angina pectoris...
This man feels he is living
on borrowed time.

During anginal attacks, patients may suffer intense apprehension. More frequently, however, they experience a continuing sense of less severe but nonetheless disproportionate anxiety.

Reduction of such clinically significant anxiety is important, since undue emotional stress may precipitate further anginal episodes.

Adjunctive Librium (chlordiazepoxide HCl) may be especially suitable for relief of clinically significant anxiety and emotional tension in anginal patients because of its generally prompt therapeutic effectiveness and wide margin of safety. In a recent double-blind randomized study,* Librium (chlordiazepoxide HCl) was administered for relief of moderate anxiety in 20 anginal patients seen in office practice over a 20-week period. Symptoms of emotional distress related to anxiety were rated at base-line, one week, two weeks and monthly thereafter. Relief was obtained notably early in therapy. The clinical results demonstrated that Librium offers the coronary patient an antianxiety drug that, in the author's opinion, is both effective and safe. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated. (See summary of prescribing information.)

Librium (chlordiazepoxide HCl) is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics and antihypertensive agents, whenever anxiety is clinically significant. The drug should be discontinued after anxiety has been reduced to appropriate levels.

The positive power of adjunctive Librium® (chlordiazepoxide HCl)

10-mg, 25-mg capsules up to 100 mg daily

for moderate to severe anxiety accompanying angina pectoris

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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*Levine, S.: "Angina Pectoris and Emotional Overlay," Scientific Exhibit presented at the Annual Meeting of the Maine Medical Association, Kennebunkport, Me., June 13-15, 1971.

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SEPTEMBER COVER—My Symphony by William Ellery Channing (1818-1901).

President's Page



Medical Education

Continuing medical education is important to all of us in the practice of medicine but the number of scientific programs given over the country each year has almost gotten out of hand. We are deluged daily with brochures outlining interesting and outstanding medical programs; it is not unusual to have two different scientific programs on the same subject going on in our state at the same time without either organization being aware the other program is being presented.

In Florida this year, we are hoping to begin to tie together many of the loose ends involved with postgraduate teaching and medical presentations. By using our FMA Council on Scientific Activities, our medical school faculties, and the Florida Regional Medical Program, it is hoped that we will be able to coordinate our teaching efforts. We have a host of talent available and the product of their efforts should be great. Your FMA Council on Scientific Activities is headed by Dr. James M. Ingram of Tampa, who is currently on the full-time faculty of the University of South Florida medical school but has previously been in full-time private practice. The Committee on Continuing Medical Education, headed by Dr. Michael J. Pickering of Lakeland, and the Committee on Regional Medical Program, headed by Dr. James C. Hirschman of Miami, are a part of Dr. Ingram's council. The following group of men serve as consultants to the Committee for Continuing Medical Education: Max Michael Jr., M.D. (Florida Director of Medical Education), John McBride (Florida Hospital Association), Gordon Engebretson, Ph.D. (Florida Regional Medical Program), and Francis C. Coleman, M.D. (Chairman, Advisory Council, Community Hospital Education Act).

The Community Hospital Education Act of Florida is a new program created by the last Legislature. Monies were appropriated to finance resident and intern teaching in hospitals not directly affiliated with medical schools in our state. Dr. Francis Coleman was appointed to this original Advisory Council, and is currently serving as the first chairman and we are fortunate to have his guidance in the early planning stages of this new program.

Doctor Pickering also has representatives on his Committee from each of the medical schools in Florida, as well as men in the private practice of medicine who are interested in medical education. With all this teaching talent and knowhow, plus the administrative and financial help of the Regional Medical Program, it seems to me that we can be looking forward to new ideas and attractive presentations to keep us all up-to-date.

Your Committee on Scientific Assemblies, which also works under Doctor Ingram's Council, will be working closely with the above men in preparing scientific programs for our annual meeting next year at the Americana Hotel. Gerold L. Schiebler, M.D. of the University of Florida College of Medicine faculty, is heading up this group and will be ably aided by his committeemen: W. Dean Steward, M.D. (Orlando), Calvin W. Martin, M.D. (Arcadia), Raul I. Lopez, M.D. (Lakeland), and George L. Irvin III, M.D. (Miami).

With this group of men working, we can expect big things. If you have any ideas or suggestions which would improve our Continuing Medical Education Program, don't hesitate to let me or Dr. James Ingram hear from you. I can assure you your thoughts will be appreciated and considered.

William J. Dean, M.D.

Arthur lost



A single-dose, non-staining anthelmi

is pinworms...



with just one non-staining dose of Antiminth (pyrantel pamoate) Oral Suspension.

Highly effective. Active against pinworm...and roundworm.

Non-staining. Doesn't stain teeth or oral mucosa on ingestion. Doesn't stain stools, clothing or linen.

Simple dosage. Single-dose regimen: 1 cc. per 10 lbs. of body weight (1 tsp. per 50 lbs.).

Well-tolerated. Based on pre-introductory studies.

Pleasant-tasting. Easy-to-take, caramel-flavored oral suspension.

Economical. One prescription for the entire family.

Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 μg/ml) are reached in 1-3 hours. Ouantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia.

Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lbs. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day; and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices. Because of limited data on repeated doses, no recommendations can be made

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles.

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(pyrantel pamoate)

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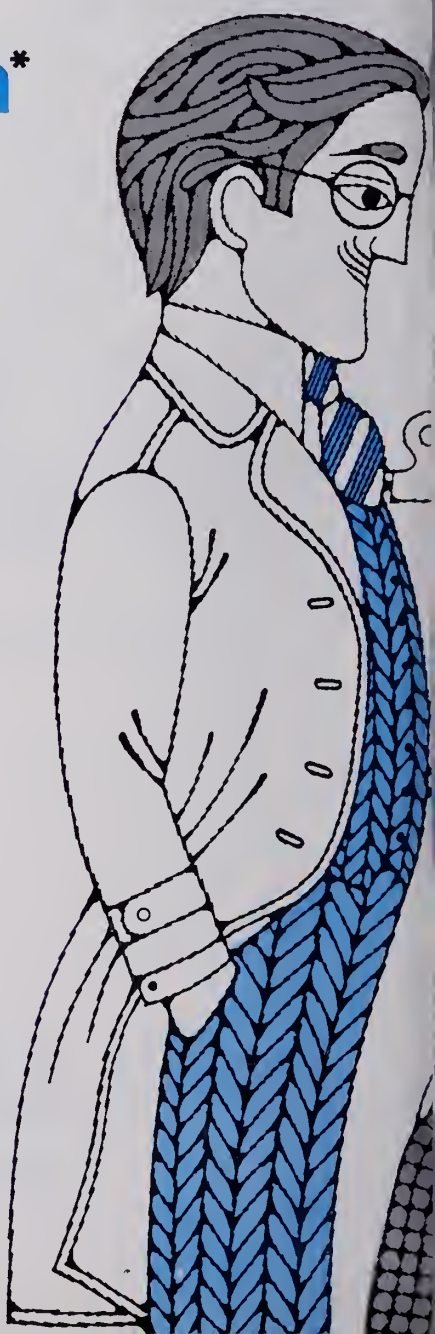
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saves time, compiles comprehensive data, aids evaluation



Two new components now make it possible to tailor the ROCOM Health History System to your precise needs. Each item is designed to speed both the collection and review of the complex data you need to make informed decisions.

Patient Data Base System is recommended whenever you schedule a periodic health check-up, or a physical exam for a new patient. The patient completes the comprehensive Health History Questionnaire section before his appointment...your aide enters the results of routine physical measurements and diagnostic tests...and you record the results of your examination quickly and easily on the 18-category physical examination section. Space for a summary of problems and treatment plans is also provided in this single compact folder, which then becomes part of your permanent records.

Branching Health History Questionnaires explore in detail (100-250 questions each) the specific body system in question – Cardiovascular, Gastrointestinal, Respiratory or Ob/Gyn. Each positive answer is automatically transferred to your summary sheet. You begin your review with a complete outline to assist you in determining your diagnosis. Each branching questionnaire contains an abbreviated general background section so that it may be used alone or as an adjunct to any other component in the system.

These new elements, together with the original components, provide you with an optional system for simplified data collection.

Health History Questionnaire can be used instead of the Patient Data Base System when a physical exam has not been scheduled. All pertinent information is covered: family history, past and present illnesses, hospitalizations, immunizations, current medications and known allergies. Current health status is reviewed by 129 carefully chosen questions.

Health History Questionnaire (Spanish) proves invaluable when the patient's knowledge of English is limited. The questions are in Spanish... your summary sheet is in English. The form does the "translating" for you.

*Created and developed by Patient Care Systems, Inc

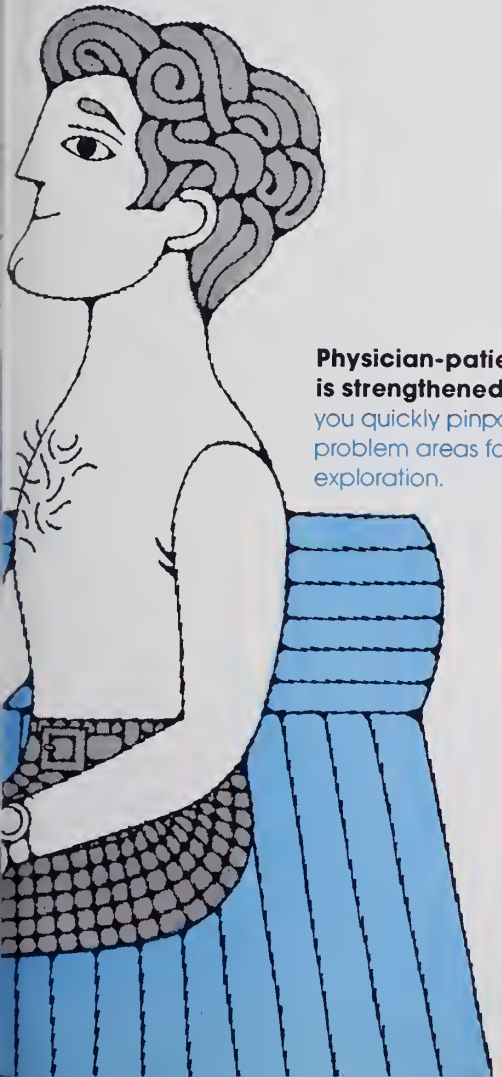


The patient does the time-consuming work before you see him. The questionnaire may be mailed to his home or filled out in your office prior to his appointment.



You get a complete summary at a glance. Only positive answers are transferred, by special pressure-sensitive paper, to your summary sheet. The form speeds review, aids diagnosis, files easily.





Physician-patient rapport is strengthened since you quickly pinpoint problem areas for further exploration.

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Gentlemen: I'd like to know more about the Health History System and the other components of the ROCOM Medical Management System: Medical Record System, Patient Health Guides, Telephone System and Appointment System.

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Street _____

City _____ State _____ Zip _____

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MMS - 10H

Pinworm therapy is often a family affair





Contraindications: History of hypersensitivity to thiabendazole.
Warnings: If hypersensitivity reactions occur, drug should be discontinued immediately and not resumed. Rarely, erythema multiforme has been associated with thiabendazole therapy; in severe cases (Stevens-Johnson syndrome), fatalities have occurred. Because CNS side effects may occur quite frequently, activities requiring mental alertness should be avoided. Safe use in pregnancy or lactation has not been established.
Precautions: Ideally, supportive therapy is indicated for anemic, dehydrated, or malnourished patients prior to initiation of anthelmintic therapy. In presence of hepatic or renal dysfunction, patients should be carefully monitored.
Adverse Reactions: Most frequently encountered are anorexia, nausea, vomiting, and dizziness. Less frequently, diarrhea, epigastric distress, pruritus, weariness, drowsiness, giddiness, and headache have occurred. Rarely, tinnitus, hyperirritability, numbness, abnormal sensation in eyes, blurring of vision, xanthopsia; hypotension, collapse; enuresis; transient rise in cephalin flocculation and SGOT; perianal rash, cholestasis and parenchymal liver damage; hyperglycemia; transient leukopenia malodor of the urine, crystalluria, hematuria; appearance of liv Ascaris in the mouth and nose. Hypersensitivity reactions

A New Dosage Form:

Chewable Tablets 500 mg

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everyone in the family
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clude: fever, facial flush, chills, conjunctival injection, gioedema, anaphylaxis, skin rashes, erythema multiforme cluding Stevens-Johnson syndrome), and lymphadenopathy.
pplied: Chewable tablets, containing 500 mg thiabendazole, boxes of 36, strip packaged, individually foil wrapped; spension, containing 500 mg thiabendazole per 5 cc, in ttles of 120 cc.

r more detailed information, consult your MSD representa-e or see the Direction Circular. Merck Sharp & Dohme, vision of Merck & Co., Inc., West Point, Pa. 19486

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addendum

INDICATION | DOSAGE SCHEDULE

MINTEZOL® (Thiabendazole, MSD) has demonstrated effectiveness against a broad spectrum of nematode infestations, whether encountered singly or in combination. Dosages are weight related; therefore, a weight-dose chart is included in the Direction Circular for your convenience when writing a prescription. MINTEZOL should be given after meals if possible.

INDICATIONS	DOSAGE (1st Day)	ADDITIONAL REGIMEN	COMMENTS
Pinworm disease	Two doses of 1 tablet/50 lb	Repeat 7 days later	This regimen is designed to reduce the risk of reinfection. However, if not practical, repeat the regimen the next day.
Threadworm,* large roundworm,* hookworm,* and whipworm* disease	Two doses of 1 tablet/50 lb	Repeat the next day	Alternatively, a single dose of 2 tablets/50 lb may be given. However, a higher incidence of side effects should be expected.
Creeping eruption	Two doses of 1 tablet/50 lb	Repeat the next day	If active lesions are still present 2 days after completing this regimen, a second course is recommended.
Symptoms of trichinosis* during the invasive phase of the disease	Two doses of 1 tablet/50 lb	Repeat for 2 to 4 successive days	The optimal dosage for the treatment of trichinosis has not been established.

The recommended maximal daily dosage is 3 g (6 tablets).

*Clinical experience with thiabendazole for treatment of each of these conditions in children weighing less than 30 lb has been limited.

Medical News

Dr. Thomas, Past President, Dies

William C. Thomas Sr., M.D., of Gainesville, a Past President of the Florida Medical Association, died in that city on July 31. He was 81.

A native of Georgia, Dr. Thomas had practiced in Gainesville since 1924. He received his A.B. degree from Emory University in Atlanta, and was awarded the M.D. degree by Johns Hopkins Medical School, interning at Union Memorial Hospital in Baltimore in 1915.

Dr. Thomas was a Fellow of the American College of Surgeons and the American College of Obstetricians and Gynecologists. He was President of FMA in 1947.

A high point in his career came in 1965 when the Florida Academy of General Practice presented him the Art of Medicine Award "in recognition of his belief, proven by personal example, that the patient receives the full benefit of total care only when the science of medicine is practiced as an art."

He leaves his widow; a son, W. C. Thomas Jr., M.D.; daughters, Mrs. Lee (Betty) Graham and Mrs. Virginia Alison, both of Tallahassee; 11 grandchildren and two great grandchildren.

Cancer Education Seminar

"Changing Concepts of Cancer of the Female Breast" will be the subject for the Cancer Education Seminar to be conducted by the St. Vincent's Medical Center Cancer Education Program in Jacksonville on September 22.

Information may be obtained from: Bonnie Turman, St. Vincent's Hospital Cancer Education Program, Barrs and St. Johns Avenue, Jacksonville, Fla. 32203.

Pulmonary Physiology Seminar

A course in pulmonary physiology and function will be held at the Veterans Hospital in Charleston, S.C., Oct. 2-6, under the sponsorship of the South Carolina Regional Medical Program and the Medical University of South Carolina.

A registration fee of $40 will be charged.

Information may be obtained from Vince Moseley, M.D., Director of Continuing Education, Medical University of South Carolina, 80 Barre Street, Charleston, S.C. 29401.

Industrial Medical Association Meeting

The Sixth Florida Industrial Health Conference will be held at the Seville Hotel in Miami Beach, October 13-14, under the sponsorship of the Industrial Medical Association and the Florida State Association of Industrial Nurses.

Discussion topics will include workmen's compensation, low back pain, fire and rescue telemetry, and rehabilitation.

Information may be obtained by contacting Joseph A. Baird, M.D., Secretary, Florida Industrial Medical Association, 701 Harbor Drive, Belleair Beach, Fla. 33535.

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and Efudex® (fluorouracil) 5% cream can resolve it.

Call it actinic, solar or senile keratoses, many regard it as "precancerous."[1,2]

Topical fluorouracil, considered by some dermatologists to be a major advance in the treatment of multiple solar keratoses,[3,4] offers the physician a relatively inexpensive alternative to cryosurgery, electrodesiccation and cold knife surgery. Of the topical fluorouracils available, only Efudex offers 2% and 5% solution and 5% cream formulations—formulations that have proved effective in the treatment of these mutliple lesions.

Usual duration of therapy, 2 to 4 weeks.

Studies showed that with the 2% and 5% Efudex preparations, the usual duration of therapy was only 2 to 4 weeks.[5] Other studies with topical fluorouracil revealed that when concentrations of less than 2% were used, significant numbers of lesions recurred.[6]

Treats the lesions you can't see, too.

Numerous lesions, not apparent prior to 2% and 5% Efudex therapy, manifested themselves by definite reactions, while intervening skin remained relatively unaffected.[5] The early eradication of these subclinical lesions (which may otherwise have undergone further progression) probably accounts for the reduced incidence of future solar keratoses in patients treated with topical fluorouracil—especially with 5% concentrations.[6]

How to identify solar keratoses.

Typically, the lesion—a flat or slightly elevated brown to red-brown papule—is dry, rough, adherent and sharply defined. Multiple lesions are the rule.

Predictable therapeutic response.

The response to a typical course of Efudex therapy is usually characteristic and predictable. After 3 or 4 days of treatment, erythema begins to appear in the area of keratoses. This is followed by a moderate to intense inflammatory response, scaling and occasionally moderate tenderness or pain. The height of this response generally occurs two weeks after the start of therapy and then begins to subside as treatment is stopped. Within two weeks of discontinuing medication, the inflammation is usually gone. Lesions that do not respond should be biopsied.

References: 1. Allen, A. C.: *The Skin, A Clinicopathological Treatise*, ed. 2, New York, Grune & Stratton, 1967, p. 842. 2. Dillaha, C. J.; Jansen, G. T., and Honeycutt, W. M.: "Treatment of Actinic Keratoses with Topical Fluorouracil," in Waisman, M. (ed.): *Pharmaceutical Therapeutics in Dermatology*, Springfield, Ill., Charles C Thomas, 1968, p. 92. 3. Belisario, J. C.: *Cutis*, *6*:293, 1970. 4. Sams, W. M.: *Arch. Derm.*, *97*:14, 1968. 5. Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey. 6. Williams, A. C., and Klein, E.: *Cancer*, *25*:450, 1970.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).



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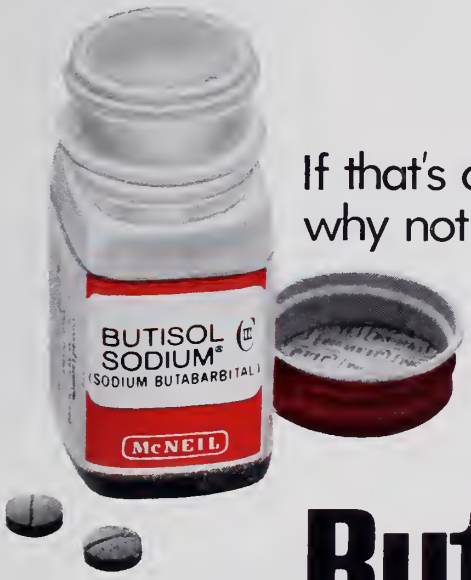
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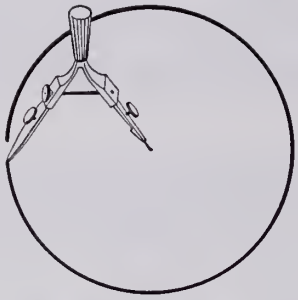
Tablets 15 mg., 30 mg.
Elixir 30 mg./5 cc. (alcohol 7%)

Indications: Useful as a daytime sedative when mild sedation is required for relief of symptoms of anxiety or tension resulting from emotional, physical, or situational stress.
Contraindications: Porphyria or sensitivity to barbiturates. **Warning:** May be habit forming.
Precautions: Exercise caution in moderate to severe hepatic disease. Elderly or debilitated patients may react with marked excitement or depression. **Adverse Reactions:** Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and systemic disturbances are seldom seen.
Usual Adult Dosage: For daytime sedation, 15 mg. to 30 mg. t.i.d. or q.i.d.
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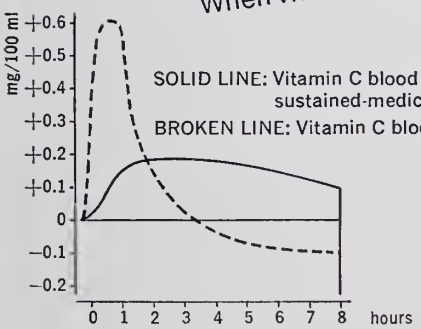


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"This method [CEVI-BID] provides a more satisfactory treatment of disorders requiring administration of vitamin C in repeated doses of relatively small amounts."[1]

When vitamin C is indicated . . . prescribe CEVI-BID.



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*Comparison of ascorbic acid blood levels after administration of 1 gram of ascorbic acid in effervescent tablet form and 1 gram of CEVI-BID (2 capsules). *Adaptation

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1. Riccitelli, M. L.: Vitamin C Therapy in Geriatric Practice, J. Amer. Geriatrics Soc. 20: 34, 1972.

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FEEDBACK - from Pearl Street

With this issue of the *Journal,* we inaugurate a new feature, *FEEDBACK—from Pearl Street.* It is intended to be a column of great interest and usefulness to the practicing physicians of this state and, in fact, was inspired by a notable Florida clinician. The editors of the *Journal,* acting on his suggestion, requested the Division of Health to provide a regular summary of communicable disease information. After much discussion, philosophical cogitation, and many attempts to realistically appraise the needs and desires of the several interested parties, this column was conceived and is now born.

For an organ of a state medical society to solicit and publish information from its own state health department is well-precedented. It is in the finest tradition of American medicine. But this effort is unique. An interpretive, readable—at times even "breezy"—narrative replaces the usual cold display of statistical data. This column will not be a list of numbers, rates or percentages. It will serve as a newsletter to *give back* to doctors seeing patients that information which each doctor individually reports to the Division of Health. And, that information will already have been verified, sorted, analyzed, and correlated when it is here printed, so that the *significance* of the data can be discussed.

A physician who suddenly sees two or three cases of apparent measles would have great difficulty in determining if this were an isolated phenomenon or the harbinger of a community-wide outbreak. In the former instance, symptomatic treatment and reassurance to interested parents and school officials would be required. In the latter, a mass immunization campaign for epidemic containment would be desirable; however, a glance at this page would give valuable and otherwise unobtainable intelligence to serve as a guide in the daily practice of medicine. It would tell that physician what his fellow practitioners are seeing, the current status of reported measles cases in the area, and what diseases currently "going around" might be masquerading as measles.

The Florida Division of Health is headquartered on Pearl Street at Hogan's Creek in Jacksonville. Among its workers are many competent and truly wonderful citizens who have dedicated their lives to improving the health of the Sunshine State. The title, *FEEDBACK—from Pearl Street,* alludes to this place where public health employees, in a common spirit with those in the private sector, come each day to work. The normal bureaucracy of the state government has yielded to this innovative request from private medicine, and timely current items of vital concern to patient care will be presented in the newsworthy and "unofficial" format required to meet the goal of FEEDBACK.

This is an experiment in improved communication.

Typhoid Again Rears Its Ugly Head

Four cases of typhoid fever have just been reported, one each in Alachua, Broward, Lee, and Palm Beach Counties. Epidemiologic investigation is proceeding, and results to date indicate that the Broward and Lee cases were acquired abroad (Taiwan and North Africa, respectively). The Palm Beach case is linked to an Alabama case, both having shared a meal on 14 June aboard a fishing boat in Baldwin County, Alabama. The Alachua case is a 10-year old girl, and was apparently acquired in Florida. Physicians should be alert to the possibility of this disease, especially in those having recently returned from Mexico, where a chloramphenicol-resistant outbreak is reported.

JFMA
THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.
SEPTEMBER, 1972 • VOLUME 59 • NUMBER 9

Reconstruction of the Abdominal Aorta in a Community Hospital

M. A. Nesmith Jr., M.D. and C. L. Park Jr., M.D.

Abstract: During the preceding eight years, the authors have performed 53 aortic abdominal reconstructions in a community hospital of 180 beds. The hospital mortality of 7.7% in elective, and 18% in ruptured aneurysmectomy compares favorably with that of larger centers. Preoperative preparation for elective surgery includes discontinuing smoking, prophylactic digitalization, bowel preparation, and intermittent positive pressure breathing. Intraoperative use of low molecular weight dextran for its antithrombogenic effect, Mannitol to maintain urinary output, local rather that systemic heparin and Fogarty embolectomy as necessary is felt to decrease the incidence of complications. Post-operatively in the Intensive Care Unit, urinary output, venous pressure, and blood gases are monitored as indicated. With increasing government sponsorship of medical care, it is conceivable that the various sponsoring agencies will specify where and by whom this care will be provided; for example, an elective aortic reconstruction might be referred to a medical center. It is suggested that surgeons practicing in smaller community hospitals review and document their results in handling some of the more difficult surgical problems.

In this age of ever increasing government provision of medical care, it is conceivable that in the future the sponsoring agency may designate where and by whom this care will be provided. It is not inconceivable that agencies such as Medicare, Medicaid or Vocational Rehabilitation will require that a procedure such as elective reconstruction of the abdominal aorta be done in a larger center. Because it is not feasible to transfer patients with acutely ruptured aneurysms to such facilities, surgery must be performed in their own community hospitals. Therefore, in order to salvage these patients, both the surgeons and the operating room teams must perform elective resection of abdominal aortic aneurysms to maintain the high degree of skill necessary for successful management of these desperately ill patients. We believe that elective resection can be safely carried out in smaller hospitals and that results will approximate those of medical centers.

It is our belief, then, that it behooves those of us who practice in smaller community hospitals to review and document our results in handling some of the more difficult problems. With these thoughts in mind, we have reviewed our cases of abdominal aortic reconstruction. These patients were operated on in Seminole Memorial Hospital, a community hospital of 180 beds, serving a population of 40 to 50 thousand.

The first successful resection of an abdominal aortic aneurysm was done in Paris in 1951 by Dr. Dubost.[1] The first successful resection of an ab-

dominal aneurysm at Seminole Memorial Hospital was done 12 years later in 1963. In the eight years from February 1964 to January 1972, we have performed 53 precedures* on 51 patients to reconstruct the abdominal aorta. These include 37 aneurysm resections and 16 aortic reconstructions for occlusive disease. Eleven of the aneurysms were ruptured and 26 were not. Eleven bypass grafts and five endarterectomies were done for occlusive disease.

The average age of all patients was 66 years; the average age of the aneurysm patients being 69 years and that of the occlusive disease patients being 59 years. The youngest patient was 43 and the oldest 82 years of age.

Forty-nine or 96% of these patients were white and 43 or 84% were male.

Associated disease was present in 77% of all patients. Thirty percent were hypertensive, 40% had had a previous myocardial infarction, congestive heart failure or angina. Thirty-eight percent had chronic pulmonary disease and 12% had cerebral ischemia or previous stroke. Only 6% were diabetic.

Concomitant unrelated procedures were done in four patients; two cholecystectomies, one Meckels diverticulectomy and one inguinal herniorrhaphy were done at the time of aortic reconstruction.

Fifty-three procedures have been performed on 51 patients with five hospital deaths for a hospital mortality of 9.4%. Twenty-six elective aneurysms were done with two hospital deaths; a mortality of 7.7%. Of the eleven patients with ruptured aneurysms, two or 18% died in the hospital. Sixteen aortic occlusions were corrected with one hospital death for a mortality of 6.2%. This compares favorably with the mortality figures from other institutions (Table 1).

Of the five hospital deaths, two patients had ruptured aneurysms, one dying in congestive heart failure with arrhythmia and pneumonia as complicating factors. The other patient was eating, vomited and aspirated on the fifth postoperative day. Two of the deaths were in elective aneurysm resections; one, the first patient in our series, died of postoperative bleeding and distal thrombosis. An unsuccessful attempt at thrombectomy was made; this being prior to the use of Fogarty catheters. One elective aneurysm patient died the day prior to anticipated discharge of acute myocardial infarction. The fifth hospital death was in a patient operated on for occlusive disease who died in intractable heart failure and ventricular tachycardia.

Table 1.—Sampling of Hospital Mortality in Abdominal Aortic Aneurysm Surgery.

Center	Year	Elective	Ruptured
Mass. Gen. Hosp.	1970	2.6%	40%
Yale Univ.	1970	13.0%	60%
Baylor Univ.	1966	7.0%	34%
Barnes Hosp.	1967	17.0%	61%
Present Series	1972	7.7%	18%

*Three of these procedures were done by Dr. Kenneth Wing with one of us as assistant. We appreciate his allowing the addition of these cases to our series.

Nonfatal complications that occurred in the hospital are summarized in Table 2. The most serious of these was a postoperative cerebral thrombosis resulting in a hemiplegia. Three patients required reoperation in the postoperative period, one for small bowel obstruction, one for aortic reocclusion, and one for intra-abdominal postoperative bleeding.

Late complications that were nonfatal are listed in Table 3. Five patients have been reoperated on for late small bowel obstruction. Two patients have required nephrectomy. One was due to renal infarction six weeks after discharge following aortic endarterectomy. The other was due to an unsuccessful repair of a severed right ureter. This occurred during surgery for a ruptured aneurysm of the distal aorta and right common iliac artery in which the right ureter was displaced medially to the ruptured right iliac aneurysm. One patient has survived following surgery for duodenal erosion by the graft. One patient required reoperation for aortic graft occlusion two years postoperatively.

Six patients are known to have died of unrelated causes; one patient at six months, three at two years, and one patient each at four and six years postoperatively. One patient died at home of a pulmonary embolus in the early postoperative period. Three patients have been lost to follow-up. The remaining 36 patients are known to be alive and well at this time.

In the preparation of a patient for elective aortic surgery the following factors appear to be beneficial. 1. The patient is asked to discontinue smoking for two weeks prior to surgery. Intermittent positive pressure is utilized preoperatively to familiarize the patient with the respirator. 2. Prophylactic digitalis is used in all patients seeking the following effects summarized by Couch et al:[2] (a) reduction of negative inotropic effects of anesthetics demonstrated by Goldberg et al,[3] (b) reduction of the incidence of postoperative atrial arrhythmias shown by Wheat and Burford,[4] and (c) reduction of ventricular rate should atrial arrhythmia occur, demonstrated by Selzer and

Walter.[5] 3. Bowel preparation is used to (a) collapse the bowel and aid exposure and (b) help sustain the left colon in the event a large part of its nourishment is from the inferior mesenteric vessel that is frequently sacrificed.

At surgery two or three large venous catheters are inserted, one in a large central vein so that the anesthetist may monitor venous pressure. An indwelling Foley catheter is utilized and again the anesthetist closely monitors urinary output. Low molecular weight dextran is started at the outset of the procedure in the belief that its effect on platelets will decrease sludging of blood distal to the cross-clamp, and because of its antithrombogenic effect demonstrated by Andrews et al[6] in the prevention of early occlusion of dacron arterial grafts in dogs. Mannitol is given prior to and during the cross-clamp period to maintain urinary output. We have had no problem with oliguria since we began using Mannitol.

Local rather than systemic heparin is used and it is believed that this decreases the problem of postoperative bleeding. If there is any question of distal thrombosis or embolus, a Fogarty catheter is used to open the vessel.

Aortic control is of primary importance in ruptured aortic aneurysms and at times is best accomplished intralumenally with a finger or a Fogarty catheter. It is unnecessary to resect more than the anterior wall of the aneurysm and usually the sac is simply opened and the graft is sutured inside the aneurysm. A cuff of excess graft material is used at times to cover the proximal suture line; this also aids in hemostasis. Dacron grafts are preferred because they are better incorporated into the surrounding tissue than are teflon. Prosthetic suture material is used rather than silk because of the latter's tendency to lose its tensile strength with time and break, causing false aneurysms.

A temporary gastrostomy tube is routinely inserted to avoid the complications and discomfort of a nasogastric tube.

From the recovery room the patient is transferred to the Intensive Care Unit, usually with the endotracheal tube in place. This is not removed until the patient is fully reactive and exchanging well. Venous pressure and urinary output are again closely monitored and as indicated arterial blood gases are analyzed. Many of these patients have chronic pulmonary disease and not infrequently a tracheostomy is indicated for improved tracheal toilet and assisted ventilation.

In a patient receiving positive pressure ventilation with a mask, it is important to open the gastrostomy tube during the treatment to prevent gastric dilatation. Localized duodenal ileus is frequent and accounted for one of the deaths in our series. Although the patient was having stools, he developed gastric dilatation, vomited and aspirated. The duodenal ileus is due to the extensive mobilization of the third portion that is often necessary.

Early ambulation and postoperative dextran administration, it is believed, will decrease the incidence of pulmonary emboli.

Fifty-one patients in our series underwent 53 procedures for reconstruction of the abdominal aorta with an overall mortality of 9.4%. Forty-two elective aortic reconstructions were done with a mortality of 7.1%. Eleven patients with ruptured aneurysms were operated on with a hospital mortality of 18%. Preoperative, intraoperative and postoperative precautions that we believe beneficial in decreasing the mortality rate have been discussed.

Table 2.—Nonfatal Postoperative Hospital Complications.

Pulmonary	5
Intestinal Obstruction	2
Severe Diarrhea	2
Cardiac	1
Massive GI Bleeding	1
Hepatic Insufficiency	1
Postoperative Bleeding	1
Aortic Thrombosis	1
Distal Embolus	1
Cerebral Thrombosis	1
Wound Infection	1

Table 3.—Late Complications.

Intestinal Obstruction	5
Nephrectomy	2
Duodenal Erosion	1
Graft Occlusion	1
Serum Hepatitis	1

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Research in the Delivery of Female Health Care

Effort and Effectiveness, Revisited

Berel Held, M.D., Paul Burgess, L.Th., M.S.P.H., Jose Gilibert, M.D., and Harry Prystowsky, M.D.

Abstract: In 1970 an analysis of 502 low income pregnant patients registered in the University of Florida multicounty female health care program was conducted. Planned pregnancies accounted for only 14 percent of the total, and greater than half of the population had received no contraceptive services prior to pregnancy. These patients have been revisited, and as a result of program design modification, the effectiveness of the Department of Obstetrics and Gynecology in performing its mission as the primary provider of female health care to a rural indigent population is again evaluated. From the data collected it would appear that the effort now expended does parallel effectiveness of service.

In a previous communication,[1] an attempt was made to assess the effectiveness of a Department of Obstetrics and Gynecology in the role of the primary provider of one aspect of female health care, i.e., family planning. In contradistinction to other reports,[2-4] the above-mentioned concerned itself with a group of patients who were currently registered for prenatal care and delivery, but who also had been exposed to a community-wide program for nonpregnant women prior to their gestation.

The objective of the previous study was to provide some sort of objective evaluation, for the Department had committed considerable resources and time to the project. Granting agencies had provided modest funds. The role of the University in this activity was being questioned. And, finally, the staff of two divisions within the Department were genuinely concerned with the widespread acceptance of certain models of female health care which had as their single theme the provider and the consumer, coupled with the presence of varied types of allied professionals.

Demographic and other data were presented. They were of importance for they defined and described the population involved in a given geographic area in a precisely defined system of health care delivery and at a given point in time—all important in conducting research. The key point of the report, however, was not its descriptive and/or philosophic recordings. The fact emerged that the Department had failed in its mission.

In an attempt to improve effort, a series of changes were instituted. Much of the program planning was modified. One year later the same patients have been revisited. The data collected form the basis of this report.

Materials and Methods

The 502 females who were under care as gravidas in 1970 still remain the responsibility of the Department of Obstetrics and Gynecology regarding female health care and, in particular, family planning. Thirty-two have moved from the target area and 76 have been lost to follow-up. From the original study population, analysis was conducted on 394 (78%). The McBee Keysort System was utilized to record and collate data.

Results

Four patients (1%) are presently pregnant. Three of them are teenagers. They represent unplanned gestations and none was on contraception prior to pregnancy—the same situation a year ago.

The remainder of the patient population is analyzed in detail for they relate directly to program and departmental effort.

Twenty-nine (7%) requested and were afforded surgical sterilization. Of this group, nine were unmarried. Six were less than 20 years of age. Five were primigravidas.

Contraceptive modality chosen postpartum with reference to race (Fig. 1).

In contrast to the large percentage who utilized no contraception prior to the last gestation, the

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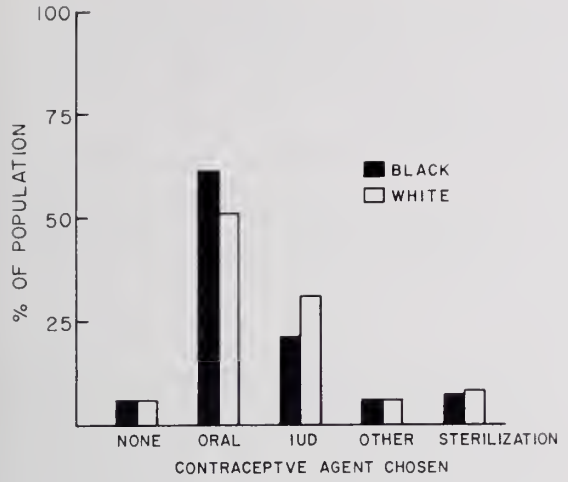


Fig. 1.—Contraceptive modality chosen postpartum with reference to race.

percentage in this category is now only 5.1% (black and white). Greater than ½ continue to prefer the oral contraceptive. The difference in usage between the black and the white is over 10%. There is also racial disparity in the usage of the intrauterine device. It is more favored amongst the white (32% vs. 21%). No racial differences are noted in regard to other contraceptive or surgical sterilization.

Contraceptive modality chosen postpartum with reference to age (Fig. 2).

Percentage of users of oral contraceptives declines with advancing age. With increasing age, the incidence of surgical sterilization rises. It represents the procedure of choice by nearly 1/3 of subjects more than 35 years of age. The intrauterine device is used infrequently by teenagers. "Other" methods (foam, condom, diaphragm, etc.) are almost exclusively utilized by those 20-34 years of age but not at all by women over 35 and less than 15.

Contraceptive modality chosen postpartum with reference to parity (Fig. 3).

The usage of the oral contraceptive declines with increasing parity. A woman with four or more children is as apt to use the intrauterine device as is the primiparous individual. In the former category, 28% elected surgical sterilization as the procedure of choice. "Other" means are little used by women in each category. No form of contraception was present in a single group, parity 2-4.

Contraceptive modality chosen with reference to marital status (Table 1).

In both single and married individuals, the oral contraceptive is the favored means of fertility control but the difference between them is significant quantitatively. By contrast, incidence of usage of the intrauterine device is twice that in the married segment as compared to the single, 30% and 15%, respectively. In regards to all the other categories, the two are similar.

Discussion

In spite of obvious limitations in an evaluation of this sort, certain bits of data are in hand which permit us to evaluate a method of delivery of female health care. Of utmost significance is that the target population now accepts the Department as the primary provider of health care in both pregnant and nonpregnant states. Only 76 nonpregnant individuals have been lost to follow-up (15%). Another factor which bears directly upon the Department's ability to measure its impact concerns the mobility of the target population. Only 32, or 6%, of the original study group left the area.

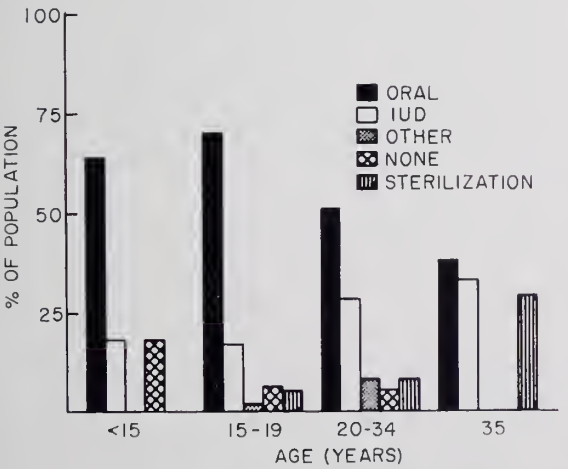


Fig. 2.—Contraceptive modality chosen postpartum with reference to age.

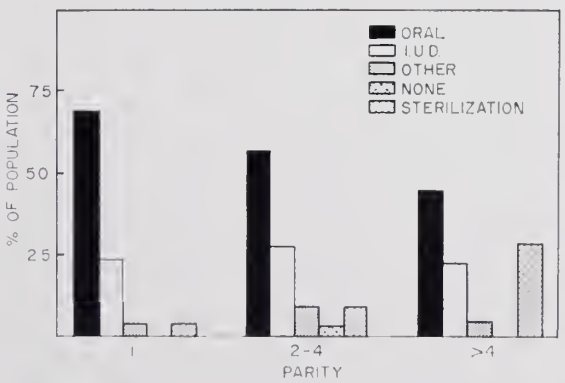


Fig. 3.—Contraceptive modality chosen postpartum with reference to parity.

Table 1.—Contraceptive Modality Chosen with Reference to Marital Status.

	ORAL	I.U.D.	OTHER	NONE	STERILIZATION
SINGLE (159)	69.8	15.1	4.4	5.7	5.0
MARRIED (231)	50.2	30.3	5.6	4.8	9.1

CONTRACEPTIVE MODALITY CHOSEN (%)

It would appear that our efforts are becoming more successful in preventing unplanned pregnancies and pregnancy timing errors. Specifically the incidence of unplanned pregnancy in the study group is only 1%. This same population just a short while ago presented a different story, i.e., greater than a half were utilizing no contraceptive agent prior to their most recent pregnancy.

The explanation of these facts are attributable to various factors. Perhaps the most important was the Department's appreciation of its failure to serve in the role of a primary provider of health care. Next was its understanding that to be effective would require the institution of a system, not just obstetric nor just gynecologic. Stated in other words, it was necessary to institute a health maintenance organization for women. Not only was physician personnel to be involved but allied professionals as well[5] plus inservice education of public health personnel.

On the basis of this experience we make three additional points:

If the patient must have knowledge of the advantages which accrue to her by becoming a contraceptor, the educational program for postpartum women adopted by the Department provides them with this knowledge.

If this knowledge must be actualized and if they must be motivated to move into the system, our efforts directed to motivation appear to be successful.

If obstacles which impede the patients' moving into the system must be dealt with, we have apparently assisted them in overcoming and/or obviating these barriers.

In conclusion, it is our feeling that for this group of women effort expended in providing female health care now parallels effectiveness of service.

Summary

Previously it has been reported that the Department of Obstetrics and Gynecology had failed in its mission as the primary provider of female health care to a rural, indigent population. A series of changes were instituted; the program design was modified. Now the patients have been revisited. From the data collected it would appear that the effort now expended does parallel effectiveness of service.

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A friend is a present you give yourself.

Robert Louis Stevenson

Funduscopy in Subacute Sclerosing Panencephalitis

Robert C. Karlsberg, M.D. and Mary Andriola, M.D.

Abstract: Fifty-two cases of SSPE are reviewed. Of these 16 were noted to have macular lesions. In addition, of five cases noted at the Shands Teaching Hospital during the past year, three had macular lesions.

The most common fundus finding was a focal chorioretinitis. This relatively slow and quiet inflammation often involves the macula where inflammatory phase and postinflammatory phase can be differentiated. The macular inflammatory phase is characterized by opalescent swelling of the macula in reminiscence of sphingolipidoses. The postinflammatory macula appears as an irregular round depigmented scar surrounded by a slightly pigmented border, often suggestive of juvenile macular degeneration.

The differential diagnosis of the SSPE maculopathy includes sphingolipidoses, juvenile macular degeneration, congenital toxoplasmosis, and retinitis medicomentosa. The characteristic differentiating fundus changes of these conditions are discussed.

Subacute sclerosing panencephalitis (SSPE) may affect the eyes in addition to the central nervous system. The ophthalmic lesions mentioned briefly in American reports[1-12] have been discussed extensively in European literature.[13-17] Earlier last year Robb and Watters called attention to the ocular manifestations in eight patients.[12]

At the American Academy of Ophthalmology and Otolaryngology meeting in October 1970, Paul R. McNeer, M.D. and J. T. Jabbour, M.D. presented an additional 11 cases emphasizing the macular lesion which resembles an acute chorioretinitis and at other times a juvenile macular degeneration. Inclusion bodies have been demonstrated only recently in the retinal lesions.

This report presents our experience with five patients seen at the Shands Teaching Hospital between August 1969 and August 1970. Particular emphasis is placed on the macular lesions found in three of them.

Case Reports

Case 1.—The 6-year-old white girl had uncomplicated measles at age 2. The parents noted increasing difficulty with behavior and brief episodes of staring during the several months prior to admission.

About one month prior to admission she presented to another hospital with difficulty walking and sudden losses of postural tone felt to be akinetic seizures. EEG showed bursts of 3/sec. spikes with slow background activity. Two spinal taps revealed normal CSF protein with no cells. She was begun on phenobarbital and zarontin and at first appeared to respond; then became more lethargic and finally stuporous with frequent myoclonic jerks in both upper extremities and was referred to our hospital.

On examination she was obtunded, responsive mainly to painful stimuli; she exhibited extension of the lower extremities and flexion of the upper extremities with tremor. Pupils were equal and reactive to light and there was a horizontal nystagmus. Funduscopy revealed bilateral pale discs. The left macular area was obscured by a white area with surrounding increased pigmentation.

Gag reflex was depressed; sucking movements occurred when anything was placed near the lips or mouth. Tone was generally increased. Little spontaneous movement was noted and on painful stimulation there was an increase of the decorticate posturing. Deep tendon reflexes were 1+ in the upper extremities and 2+ in the lower.

Significant laboratory work included: spinal tap with opening pressure of 130 mm. of water, no cells, CSF glucose 64, CFS protein 48. CSF electrophoresis revealed a greatly elevated gammaglobulin (40% of total CSF protein). The EEG revealed continuous high amplitude one-two cycle per second slow wave activity with remarkable absence of normal background activity. Measles titer was 1:64.

The parents declined permission for a brain biopsy and the patient was discharged and lost to followup.

Case 2.—The patient was born 4/19/58 and had measles at eight months of age. He presented at age ten with a history of decreased vision in the left eye for several weeks. Initial evaluation in our clinic led to a diagnosis of juvenile macular degeneration.

Six months later the parents noted the onset of clumsiness, attention gaps, slurred speech and myoclonic jerks. His school performance had markedly deteriorated. At age 11 he was hospitalized with a diagnosis of cerebroretinal

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degeneration. The cranial nerves were intact except for the decreased vision associated with the left macular lesion. Sensation was intact. Strength was normal as was tone. Cerebellar function was impaired including an ataxic gait. Reflexes were normal. He was noted to have frequent lapses of consciousness with stumbling, hesitation and confusion. He also had difficulty with memory and appeared demented.

Significant laboratory work included spinal tap with CSF protein 35, CSF glucose 58, with 2 RBC's and 10 monocytic WBC's. CSF electrophoresis revealed a marked increase in gammaglobulin (42%). The EEG revealed bursts of high amplitude sharp waves occurring every five to six seconds. Skull x-rays and pneumoencephalogram were normal.

Brain biopsy from the right frontal area revealed inflammatory cells in perivascular areas. Although no inclusion bodies were seen, diagnosis of subacute sclerosing panencephalitis was made.

Over the next year myoclonic jerks continued as did mental deterioration and behavior became an increasing problem. Rigidity, crying spells, swallowing difficulties and decreasing vision in the right eye have been noted over the last few months.

Case 3.—The patient was born 12/3/58 and had measles at age three. She was well until December 1969 when she began having "fainting spells" during which she would fall backwards and lose consciousness for several seconds. An EEG was read as technically poor with frequent movement artifacts. She was placed on Dilantin and the "spells" decreased for several months. Physical examination at this time was entirely normal including the funduscopy.

In June 1970 her mother noted her groping for objects and walking into things. In the last few weeks of school her grades had dropped precipitously. At first, symptoms were felt to represent hysteria or malingering; however, on examination, in addition to a peculiar behavior the patient was noted to be demented. She appeared to be blind, walking into furniture. Speech was slurred and repetitious and the patient cried easily. Pupils reacted poorly to light and extraocular movements appeared full without nystagmus. Funduscopy revealed normal appearing discs with the left macula obscured by white scarring surrounded by increased pigmentation (Fig. 1).

This appeared to be the manifestation of several perimacular foci of inflammation. Sensation was intact to pin and touch and could not be further tested due to lack of cooperation. Muscular tone was increased but there was no apparent weakness. Fine finger movements and coordination was fair and gait was wide based or shuffling. Deep tendon reflexes were normal and planters were flexor.

An EEG showed burst of high voltage sharp waves occurring every eight to nine seconds with absence of normal background activity. The record was felt to be quite suggestive of subacute sclerosing panencephalitis. Skull films and brain scan were normal. Spinal tap: opening pressure of 160 mm. H_2O, CSF protein 60, CSF sugar 70, 3 WBC's. CSF electrophoresis revealed a markedly elevated gammaglobulin (39%). Patient's serum had a 1:128 titer to measles.

Over the month the patient had the onset of generalized seizures and myoclonic jerks. She could no longer walk but would fall if placed in a standing position. She ceased speaking but cried frequently and was incontinent. Feeding was not yet a problem. On examination myoclonic jerking of the whole body occurred especially on the right side, and the muscular tone was generally increased. An irregular horizontal nystagmus was also noted.

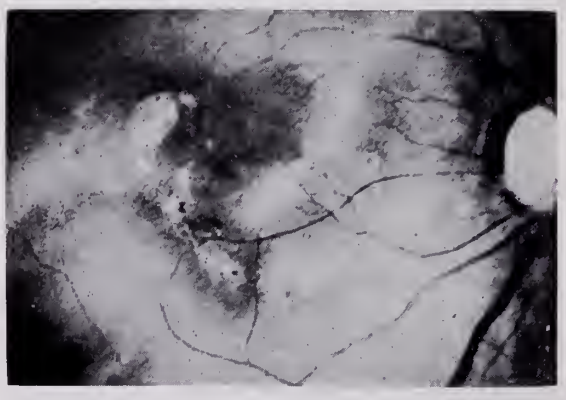


Fig. 1.—Left fundus of SSPE patient. Note macula obscured by white scarring surrounded by increased pigmentation.

History: Subacute sclerosing panencephalitis was described in 1933 by Dawson,[18,19] in 1939 by Pette and Doring[20] and in 1945 by van Bogaert[21] as separate pathological entities. In the 1950's it became apparent that the clinical and pathological features of these variously described encephalitides were very similar and represented the same disease.[8] The etiological agent was felt to be a virus but its identity remained elusive.

Rapid gains were made in the 1960's when electron microscopy of SSPE brain tissue revealed myxovirus-like particles;[22] serum and CSF of affected patients contained high titers of measles antibody;[23] and measles virus was isolated from the brain of patients with SSPE in 1969.[24,25] The infectious agent has been transmitted from affected patients to ferrets[26] and most recently to hamsters.[27] Antiviral agents such as amantadine and 5-bromo-2′-dioxyuridine[28,29] have not been successful in significantly altering the downhill course of the disease.

Clinical Picture: Patients afflicted with SSPE are usually between the ages of three and 13 years when the symptoms of mental deterioration begin[6] and in most instances it develops several years after the measles exanthem, or after having received measles vaccine. It is not clear how or why the measles virus remains latent in the brains of patients who subsequently develop SSPE or why it becomes activated in the presence of high serum and CSF antibody titers.

The disease usually has an insidious onset consisting of personality changes, behavior problems, mental dullness and falling school grades. Eventually the patient will exhibit a frank dementia plus loss of speech. These mental changes are usually accompanied by increasing clumsiness progressing to a frank ataxia. Muscle tone is usually increased to spasticity and the patient may exhibit decorticate posturing. On occasion seizures may be the presenting sign; these may be either major or minor motor or may be the typical myoclonic phenomenon.

In the final stages the patient is blind, mute and incontinent with little voluntary movement.

Swallowing becomes difficult and weight loss is apparent. Myoclonic jerks may cease. Temperature regulation may become impaired and high fevers have been recorded without apparent infection. Most patients die within two years after the disease onset.

The most common fundus finding is a focal chorioretinitis which often but not always involves the macula. The inflammatory focus is sufficiently small in size and low grade in activity as to produce only minimal vitreous reaction. Initially, there is a ground glass whitening of the retina with subsequent mottling of the retinal pigment epithelium.

When the chorioretinitis involves the macula, a rather characteristic picture can be seen. In the acute inflammatory stage, swelling and opacity of the macula with perimacular radial striae are noted. [Occasionally, hemorrhage has been seen—Otradovec, 1969]. Later in the postinflammatory phase, the macula usually presents as an irregular, round, depigmented scar surrounded by a pigmented border. In contrast to toxoplasmosis, the scar is often poorly demarcated and exhibits less destruction. The acute macular changes may precede the general symptoms by months as happened in our second case.

In 1969 Otradovec noted this maculopathy in nine of 28 patients he examined and in seven other cases described elsewhere in the literature. These changes occur binocularly in 30% of the cases. Focal chorioretinitis was present in four of the eight patients reported by Robb.[12] Of these four patients with retinopathy, two had macular lesions. Of the three patients reported by Malamud,[1] one had a bilateral maculopathy. In the three cases presented Chao,[5] one maculopathy was noted. Among eight patients with diagnosed SSPE;[6] two had a maculopathy. The autopsy of two teen-age girls who died due to SSPE demonstrated inclusion bodies in the brain and retina of each patient. However, only one of the two had a clinically evident macular lesion.[30]

Papilledema is often noted in these patients, and the antecedent increased intracranial pressure is thought to be due to either inflammatory swelling of the brain or an early communicating hydrocephalus. Optic atrophy noted in some of these patients is due to retrobulbar inflammation with retrograde neuronal degeneration. Cortical blindness is frequent and is probably the result of inflammation of the optic radiations. These patients usually have no response to visual stimuli but have normal fundi, optic nerves and reactive pupils.

Differential Diagnosis: A formerly healthy child with progressive central nervous system damage and macular lesion presents an unfortunate differential diagnosis, the sphingolipidosis and the presenile macular degenerations are the most likely to be confused with SSPE. Spielmeyer-Vogt disease was the initial diagnosis in case 2.

Infantile Tay-Sachs: Although unlikely to be confused with Dawson's due to the age of onset noted in patients with Tay-Sach's disease, it is mentioned here as it is the historic prototype of many of the sphingolipidoses. The cherry-red spot is almost always present by the time the fundi are first examined. The disc is pale or rapidly becomes pale and the retinal vessels become progressively narrowed.

Although the cherry-red spot is classically described in Tay-Sachs disease it has also been rarely seen in patients with most of the other sphingolipidoses.

Late Infantile Jansky-Bielschowsky Disease (age 2-4 years): Fundus changes similar to Tay-Sachs disease are occasionally seen; in addition, pigment mottling may be a late feature.

A cherry-red spot is sometimes apparent; however, it is less brilliant than that seen in Tay-Sachs as the white of the perimacular area tends to be masked by degeneration of pigment cells and atrophy of many of the ganglion cells surrounding the macula.

In the later stages there is a marked optic atrophy, attenuation of the retinal vessels and a varying degree of pigmentary mottling in the peripheral retina.

Juvenile Cerebromacular Degeneration (age 5-15 years): Early, the macula appears pale surrounded by a reddish-brown finely mottled areola. Later the pale area at the central macula increases in size and the red aerola becomes more pronounced with peppering or pigment. Perimacular striae may be seen. Early the optic disks may be normal; later, there is some pallor and associated narrowing of the retinal vessels in almost all cases. The peripheral retina in many cases exhibits the typical bone corpuscular pattern of retinitis pigmentosa, and may be indistinguishable from congenital syphilis and pigmentary degeneration of the retina.

The ocular manifestations are not uniform. More commonly the macular changes are prominent (the macular type of Batten-Mayou). Some-

times the peripheral pigmentary degeneration is more marked (the peripheral type of Spielmeyer-Vogt). Rarely only optic atrophy or a cherry-red spot may be seen.

Toxoplasmosis: Usually when first seen, the lesions are old and scarred and show minimal or no inflammatory reaction. The scars are large and well demarcated, mottled areas showing bare sclera surrounded by a peripheral pigmentary ring. Often the macula is destroyed with a corresponding temporal optic nerve atrophy. Bornhofen and Richardson reported a case with chorioretinitis which they felt was due to toxoplasmosis in a patient with SSPE.[3]

Retinitis Medicomentosa: Long-term high doses of phenothiazines (especially Mellaril) may produce degenerative and pigmentary changes in the macula vicinity and may produce motor difficulties as well as mental pulling.

Other conditions such as Refsum's disease, Bassen-Kornzweiz disease, Friedreich's ataxia or familial degeneration of the macula may manifest pigmentary degeneration of the retina; but other clinical and/or laboratory findings differentiate them from SSPE.[31]

Laboratory Studies: Almost all patients with SSPE demonstrate a Lange paretic type colloidal gold curve which reflects an elevation of the CSF gammaglobulin. The serum gammaglobulin is usually normal and is not the source of this increased gammaglobulin. Evidence points to its local synthesis in the brain.[32-34]

There are few diseases causing an elevated CSF gammaglobulin in the presence of normal CSF total protein and normal serum gammaglobulin, making this an extremely useful test for the diagnosis of SSPE. Multiple sclerosis and chronic CNS syphilis also cause elevation of CSF gammaglobulin but can be differentiated on clinical grounds.

The remainder of the CSF findings are usually normal in SSPE (Fig. 2). Protein electrophoresis of CSF in case 3 showed a markedly elevated gammaglobulin 39% of total protein with a double peak.

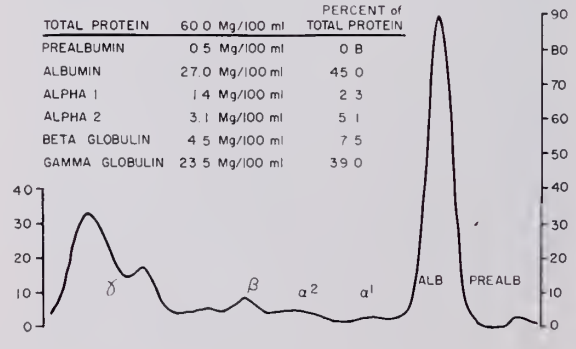


Fig. 2.—Typical CSE finding in SSPE patients.

The "classical" EEG findings in this disorder were first described in 1949 by Raadermecker.[35] Although not always present at every stage of the disease or in every patient, the "classical" EEG abnormality when recorded is helpful in confirming the diagnosis or perhaps in even suggesting it.

The waking background activity becomes slow and irregular and high voltage bilaterally synchronous bursts of sharp wave activity occur at fairly regular intervals throughout the record. The bursts are less than a second in duration and may recur every four to ten seconds. These bursts are less well seen during sleep and in the early course of the disease do not always occur at regular intervals. The EEG record obtained initially in case 3 was felt to contain many "movement artifacts." On review of this record following the second EEG it was noted that the "movement artifacts" may indeed have been irregularly occurring bursts of high voltage slow wave activity. The background activity on the initial record was essentially normal. Myoclonic activity may be associated with the bursts of sharp activity. As the disease progresses the record becomes flatter and the characteristics may disappear.[36]

The EEG tracing of case 3 shows typical bursts of generalized sharp wave activity occurring approximately every 8-13 seconds (Fig. 3).

The measles titers in the serum and CSF of the majority of affected patients are greatly elevated.[23] An elevated rubella titer is not diagnostic but its elevation long after a natural infection with measles virus strongly suggests SSPE. The exact dilutions depend on the laboratory and the method of preparing its antigen. Our patients'

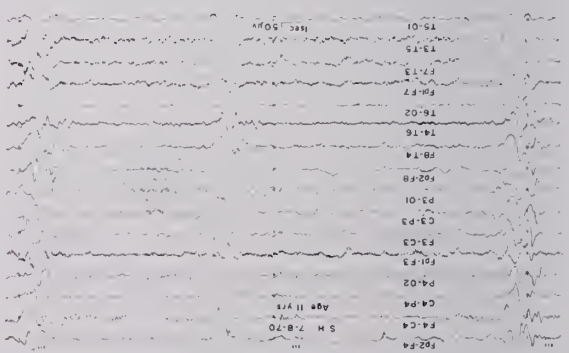


Fig. 3.—EEG tracing of three SSPE cases shows typical bursts of generalized sharp wave activity.

serums were studied at the Florida Division of Health Laboratories in Jacksonville with commercially prepared antigen, by complement fixation.

Brain biopsy may be performed on a patient if tissue confirmation is felt necessary for diagnosis. The typical findings are (a) perivascular collections of monocytic inflammatory cells in both grey and white matter, (b) degeneration of neurons which may contain Type A inclusions in either the nucleus or cytoplasma, (c) varying amounts of gliosis in either grey or white matter.[37]

Microscopic examination of sections of the globes from these patients reveals a nondescript chorioretinal scar without[12] or with[30] inclusion bodies. No electron microscopic studies have been reported.

In the presence of a characteristic clinical course, with "classical" EEG findings, elevated CSF gammaglobulin and elevated measles titers, a brain biopsy is not necessary to establish the diagnosis. The greater recognition and awareness of the features of SSPE probably accounts for the apparent increase in incidence of the disease in the past decade.

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Use of a Primate Immobilizing Agent as an Hallucinogen

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Abstract: This article deals with a new agent (Phencyclidine) being used by our young people as a hallucinogen. Since this drug is a primate immobilizing agent, it is perhaps a useful analogy to use the word "APE" in an effort to explain why anyone would use such a drug."A"—availability, "P"—peer pressure, "E"—experimentation. The effects in some cases are catastrophic, and differential diagnosis extremely difficult.

Since 1965 many dangerous substances have been used as hallucinogens—cannabis,[1] LSD, DMT, DET, DOM or STP, morning glory seeds, bufotenin and atropine. Promiscuous use of these agents has produced various bizarre psychotomimetic episodes, convulsions, coma and death. These chemical agents are sometimes taken in combination or with adulterants such as strychnine. Young people on "bum trips" are being seen in hospital emergency rooms and physicians' offices in increasing numbers and identification of the agent or agents has become virtually impossible. More recently the use of a primate immobilizing agent has further complicated the diagnosis and treatment of these cases.

Phencyclidine[2,3] (Sernylan-Parke, Davis Co.[4]) is a potent drug which produces disorientation (erratic behavior and excitement) in many species but its use is limited to primates. The drug is supplied to veterinarians as a solution for intramuscular injection in concentrations of either 20 mg. per cc. or 100 mg. per cc. in 10 cc. vials. The principal pharmacologic effect is depression of the central nervous system. The anesthetic effects produced by Sernylan are unlike those produced by classical anesthetics in that even though the animal is incapacitated or anesthetized, simple reflexes are not completely eliminated, the eyes may remain open, muscle tone is increased and respiration and blood pressure are not usually depressed. In primates the effects produced are reduced response to environment with reduced aggressiveness, recumbent immobilization without flaccid paralysis, catalepsis and analgesia. Tolerance does not ordinarily develop.

The drug first appeared as a "street" psychedelic agent in San Francisco in 1967. It was misrepresented as being THC (tetrahydrocannibal—synthetic marijuana). The drug was known as "the peace pill, PCP and hog." In powder form it was sprayed on parsley, oregano or mint leaves ("angel dust, angel hair") and smoked. The drug produced a marijuana-like high. If ingested in larger doses, PCP frequently triggered extended delusions and paranoia much like an LSD trip ("bummer"). It has been used to adulterate marijuana and a heavy chemical taste remains when it is smoked. PCP has been used as an additive to other psychedelics to create imitation "mescaline" or "psilocybin."

Phencyclidine does not produce physical dependence and only very minimal psychological dependence. In humans who take the drug to "trip out" it produces a central nervous system

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depression with distortions or sensory perceptions including body image, changes in mood, hallucinations, convulsions or death. Some individuals experience euphoria but most trips are generally unpleasant and frightful. There are no specific antidotes or therapies for bad trips or toxicity. Treatment is purely symptomatic and supportive. This was the drug responsible for "Charlie's Awful Trip"[5] in which the young man attempted to tear his eyeballs out of their sockets, leaving him totally blind.

Comments

The incidence of drug experimentation by young people is in the range of 80% to 90% (ages 8 through 17). The ready availability of the myriad of dangerous drugs and substances makes experimentation rather simple. Added to the availability of the products is peer pressure—the need to conform with what everyone else is doing. With such a percentage of young people using dangerous drugs and substances, it has become increasingly obvious that "psychopathology is not the basis for this type of conduct." Equating experimentation with criminality has created an aura of fear, frustration and humiliation in all urban communities throughout America. Parents will often not seek medical help because of an unfounded fear that the child may end up with a criminal record.

When a physician finds himself in the position of having to treat a young person who has taken a dangerous drug, it is important that he be able to answer the following questions:

1. Has the patient taken a known drug?
2. What is the dose, purity and actual identity of the black market sample?
3. Does the user know what drug he has abused?
4. Does the user have a friend with him that may know the drug he has abused?

It is important to have a laboratory analysis of the drug to make a positive diagnosis whenever possible. In the meantime the treatment is usually supportive in nature. Valium is probably the safest drug to use for agitation and other symptoms secondary to a "bum trip."

Summary

A primate immobilizing agent known as phencyclidine (Sernylan) or PCP is being used as a hallucinogenic agent by young people who believe the drug to be THC. The effects of phencyclidine are unpredictable and lead to central nervous system depression, hallucinations and all forms of abnormal behavior. It is important that the medical profession be aware of this drug and its effect on young people in today's "drug scene."

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Working With Gangs

N. Henry Pevsner, M.D., Evaristo Gomez, M.D., D.P.M., and Auguste P. Mathieu, B.S.

Abstract: Introducing situational factors leading the adolescent into the street gang social unit, guidelines are then drawn from observations among medium-sized urban gangs. Understanding the emotional pattern and energies of the adolescent is stressed. Effective programs require paramount attention to the dynamics of the adolescent personality within its realistic setting. A working relationship with a gang is formed by attention to (1) which gangs need guidance, (2) establishing contact with the gang, (3) working effectively with the gang's power structure, (4) maintaining confidence with, and influencing the gang, and (5) ultimate goals in working with gangs.

The ideal approach to resolving emotional problems of adolescents would be to deal with each teenager individually; however, this is uneconomical in cost, personnel and time. Logically, some form of group approach is more realistic but, unfortunately, the dynamics of adolescent development have already produced the antithesis of the ideal therapeutic group—the street gang.

At this age when the individual is establishing his identity, several factors prod him toward participation in street gangs. Perhaps the best clues to these factors are the more superficial statements; to paraphrase; "In a gang everyone knows who the gang is and that I'm in that gang . . . I have my friends who I can trust and who will stand up for me . . . we do things on our own—nobody pushes us around . . . not everyone can join our gang—they must be good enough and willing to do things our way." In analyzing the meaning of these remarks, first consider the crowding of people in urban areas. With huge numbers of people around him, the individual finds it harder to feel and uphold his individuality. Add to this the absent parent preoccupied with maintaining economic status, the peer group which is dominant over adolescent conduct, and the increased leisure time available to the young person whose dependent status may be extended by schooling throughout adolescence. The result is an inevitable gravitation to a social unit which will provide identity, standards of conduct, an outlet for time and energy, and feelings of independent action—the gang.

In our cities, adolescents have produced groups which by their antisocial behavior force society to deal with the serious problem of widespread, teenage street gangs.

In working with several types of gangs, a number of guidelines have evolved. This paper relates to medium-sized, adolescent street gangs (20 to 50 members) in working class, congested urban neighborhoods as seen on the west side of Chicago. Although these guidelines are not meant to apply to the severely disturbed or overtly psychotic, many disturbed and delinquent youngsters were included in the cross-section. Attention is directed at the aspects of forming a working relationship with a gang as a group: (1) which gangs need guidance, (2) establishing contact with the gang, (3) working effectively with the gang's power structure, (4) maintaining confidence with, and influencing, the gang, and (5) ultimate goals in working with gangs.

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Adolescence

Certain concepts must constantly be kept in mind when working with adolescents. Consider adolescence as a period of transition from the childish to the mature; not a straight line, rather a zigzag course with intermittent displays from both extremes—childish and mature—and episodes of curious mixtures of both. This is a time of adventure into the new experience of introspection, pubescence, personal achievements; a time to express independence, experience failure and disappointment; most importantly, perhaps, the last chance at flexibility—the last opportunity to influence the life pattern.

The primary consideration is the intensity of emotion experienced by the adolescent. This may be the least appreciated of his traits and he invariably thinks it is. This is his time for trying himself, testing situations and people around him, and he is unsure of himself. Uncertainty is not easily dispelled. His doubts about himself cause him to have doubts about the significance of his minor successes. One setback confirms his doubts, rather than many successes affirming his confidence. The result is depression and the feeling of inadequacy —loss of self-esteem.

These emotions are intense and recur daily. He wishes to hide his sense of failure from others; he does not want them to know what he thinks of himself. He hides or disguises his feelings and when those around him do not respond with understanding and consideration he forgets he is concealing them.

At the moment his feelings are the paramount of his existence. The emotion can be the strongest he has ever felt—the worst or the best—more important to him than anything can be to anyone. Fortunately, within a short time, something else becomes paramount. This intensity will magnify the reality of successes or disappointments concerning his own physical ability, interactions in his peer group, reaction on exposure to repetition of an experience, and other elements in his life.

The adolescent is not aware that his feelings may be out of proportion to the reality of the situation. He is unaware that his action in the repeat experience of a situation is guided by a previous emotional reaction perhaps more than by the real facts.

Following are other factors unconsciously motivating adolescent behavior: physical endowment or deficiency, feelings of self-importance, influence of the peer group, identification with other persons, feelings of pride and a very strong concept of revenge, reaction to criticism and discipline, datings, and accepting ideas, logic, and beliefs. Although these may be the more superficial dynamics of the personality, they occupy a large part of the adolescent's reflective time and emotional energy. They may provide a guide to the minute-to-minute social interaction of the teenager.

Which Gangs Need Guidance

When gang actions in a neighborhood become sufficiently antisocial, aroused citizens and newspapers complain to the police to control the situation. Since the problem is usually beyond the resource of the police department, city social workers, community social service agencies and local social service resources are recruited to try to work with the gangs in an effort to control, redirect, or disband them.

In a crisis situation additional resources for the police might be the best short-term solution. At the same time, some resources must be initiated in a long-range program to alleviate gang problems.

The person, who plans to work with the gang, must have something to offer that is desirable to them as a group or as individuals. The gang worker cannot go out unattached into the community, establishing personal relationships with gang members, and expect to accomplish long-range goals anywhere near commensurate with his efforts. If the worker is affiliated with some local resource to which he can bring the gang, he improves his situation. The point is that he does not have time to become a close friend to each gang member to exert a personal influence. This might succeed, but the gang worker can more effectively use his talents and maintain his own enthusiasm through wiser choices of programs.

When there are several gangs in the neighborhood, he need not start with the gang least likely to respond. It is not worth the gamble, hoping that by changing this gang the others will follow suit. Failure will be total, while success may mean that the worst gang is under control and another one has taken its place. The conditions which produced these gangs will still exist and generate the same type of gangs to replace them. Therefore, the gang to be guided should be chosen with the probability of attaining some reasonable success with its members and some success in involving them in activities which will attract other gangs and other adolescents in the community. In other words, the gang is selected for feasibility of

a long-range program which includes plans to improve the social opportunities for all adolescents in the community—attacking the immediate problem and aiming at some of the underlying causes of gang genesis at the same time. Needless to say, the gang worker should work with the gang most suitable to his background and temperament.

Establishing Contact and Working Effectively with the Gang's Power Structure

Once the gang and gang worker are paired, they are introduced to each other with their respective roles well-defined. This is accomplished by setting up very clear, minimum rules for the gang to meet tentatively at the facility. First, the leadership of the gang is recognized and meets with the director of the facility, an assistant director assigned to this gang, and the gang worker. This gives the leaders the responsibility for conduct of their group while in the facility. The next condition is the acceptance of the assistant director as their official advisor at the facility. Also, since they are a new group, the director will have the gang worker meet with them to assist them in any endeavors they may wish to undertake at the facility. While the assistant director is the ostensible advisor, he will attend only a few meetings or for only a few minutes. The gang will soon learn that the gang worker who participates very passively at meetings has the same power in the facility as their official advisor, yet his assigned loyalty is less obviously to the facility and more toward the gang's interests. This artificial setting may help to speed his acceptance by the gang members.

Maintaining Confidence with and Influencing the Gang

It is important that the worker is establishing a relationship with the members and not concentrating on the leaders. The popular idea that in order to gain acceptance it is merely sufficient to beat the leader in a fight or win him over can be a dangerous trap. The gang worker communicates at a higher intellectual level and image with gang members, rather than perpetuate their level of violence and bullying. Gang leaders are usually quite perceptive in their group and, in part, maintain their position by anticipating the desire of their members and making coinciding plans which insure the members' support. When the gang worker offers some definite advantages to the gang through the recreation facility, the leader may readily support or even propose association with the facility and gang worker. At the same time, he will consider the worker a threat to his power —an influence that the leader cannot counter. The leader may go along only to sabotage the efforts of the worker when he gets the opportunity. Therefore, it is usually unwise to reach a gang primarily through its leadership. This method would support and strengthen the leadership which, in fact, may be the part that must be weakened. The gang worker strives for the confidence of the members. The leader, who is able to sense the preference of the members, must lead the gang where it wants to be led. Undermining the leadership also tends to make the members consider their actions more as individuals. The worker offers his suggestions, ideas, and advice subtly to individual members who later present these ideas to the group as their own.

In gaining the confidence of members, the worker need not know more than the gang, he merely has to know a little more than they think he knows. For instance, he must have contacts in the neighborhood who will inform him of the gang's plans. If they are going to have a gang fight, he might mention at the meeting that he heard of a special police patrol scheduled for that time and place. This might succeed only once. If a gang member confides that he is planning to commit a crime, the worker might subtly point out where the member is taking more risk than his accomplices, or where the methods might be improved, or knowing that the member will get $20 for a stolen item from his fence, the worker will say, "that item ought to bring $40 from a decent fence . . ." and cause some doubts in the member's mind about the return for his risk. Of course this is a tremendous responsibility for the worker who is not only sanctioning a crime, but may be aiding in its commission. But the goal of the worker is to attempt guiding the gang members and if they are in jail they cannot come into the facility to be influenced in any way. This is a responsibility the worker assumes in order to win the confidence of, and exert influence over, the gang.

Through many small confidences, the worker does not succeed in causing the members to think more nobly, but they do begin to consider their actions more critically. The gang worker improves no morals of the gang, nor does he increase their sense of right and wrong or curb their violence. He provides them with a model of someone who demonstrates the value of judging their actions and the consequences in terms of their future—a

model toward more considered, mature, thought and action.

Ultimate Goals

It appears that the ultimate result will be the weakening of the gang from within, probably leading to dissolution. This, in fact, is the ultimate goal. If germinative conditions in the neighborhood persist to produce gangs, the worker may only act as a buffer, keeping many of the youngsters out of jail while there is the chance that they might outgrow some of their adolescent behavior patterns. However, if expansion of opportunity and guidance for adolescents is instituted in the neighborhood, the antisocial gangs may slowly evolve into gangs affiliated with the recreational facility, having far less destructive tendencies and perhaps some constructive goals.

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▶ Dr. Pevsner, 18901 N.E. 3rd Court, Miami 33162.

Memorandum

TO: FMA Members

FROM: W. Harold Parham, Executive Vice President

RE: FMA Professional Liability Insurance Program

Employers Fire Insurance Company has advised it will discontinue underwriting the FMA-sponsored professional liability insurance program effective January 1, 1973. Over one-half of the FMA members are covered under this program.

Negotiations are underway for a new underwriter for the program with four major reputable United States insurance companies. Three companies have already agreed to underwrite the program effective January 1, 1973, under the terms requested by the FMA. We are currently negotiating the best contract and the best program possible in the interest of the FMA members.

An orderly transfer of this program to a new company and the availability of a much improved program is contemplated.

Before considering a non-FMA-sponsored insurance carrier for your professional liability insurance coverage, we would suggest that you check the reputation, financial condition and loss experience of the company being recommended. Also a careful comparison of policy wording is imperative.

Details of the new FMA-sponsored program should be announced by the Board of Governors prior to October 1, 1972.

Suggestions for the Novice Football Doctor

Paul F. Wallace, M.D.

Abstract: This presentation, confined to high school and college athletes, is a guide to the special problems which may arise from injuries sustained during play. The team physician may find it helpful when he is called upon to accurately diagnose and institute treatment and to decide which player can return to the game safely. Initially the physician should know the team members, their personalities, for this is vital in diagnosing certain conditions.

In football there is a triple standard. A high school player cannot be treated like a college player and neither can be treated like a professional. Some procedures used and possibly condoned in professional football have no place in the high school and college. The high school player's entire future must be considered, apart from protecting him from the problems associated with the growing musculoskeletal system.

Head

Head injuries should be suspected in the boy who gets up slowly after a play. Erratic behavior such as difficulty in properly lining up or getting back into the huddle is symptomatic. Following any violent contact with the head the player should be watched for possible problems. The unconscious or dazed player requires immediate attention and when unconscious he should be examined neurologically before being moved. The helmet should not be removed until the status is determined and then only with great care because of the possibility of neck injury. A player temporarily knocked out or dazed should be out of play for a minimum of a quarter; then if he appears normal, has good recall and shows no neurological changes he may play but must be watched.

Frequently evidence of concussion is most apparent with memory loss. In addition to recalling the day, time and place, a knowledge of plays becomes a valuable criteria. This can be best determined by his responding to plays given by another team member. If he hesitates or is inaccurate, he should be benched. A more careful neurological examination should be done including a funduscopic examination. If he recovers neurologically and memory-wise by the middle of the week and shows no other effects, he could return to play the following week. After a game retinal hemorrhages may be seen in 80% of the players due primarily to totally inadequate helmets. Every effort should be made to urge the school to purchase the better types. Certainly within another year even more protective headgear will appear on the scene.

Neck

After contact, should a player be totally paralyzed and not breathing, give him immediate strong traction on the head without removing the helmet. There may be a contusion of the cord from subluxation of the spine and reduction by traction could save his life. He requires immediate hospitalization. The helmet should be removed with the greatest of care while maintaining traction and the head and neck in one position.

Sudden sharp shooting pains or numbness in an arm after contact which disappear completely after five or ten minutes represent a contusion to the brachial plexus and is usually of no real significance. The neck pain frequently can be helped by traction on the head. After complete disappearance, the player can return to the game. If this happens more than once, he certainly is a candidate for x-ray.

Chest

When the wind is knocked out of a player, a temporary period of rest, no remaining symptoms, ability to deep breathe and to jog without pain should allow the patient to return to play.

Abdomen

Abdominal injury is rare. It is essential to know the boys who have had infectious mononucleosis because their spleens are large and more apt to be ruptured.

Dr. Wallace is chairman of the Committee on Sports, Florida Orthopedic Society.

Testicles

A blow to the testicles results in immediate severe pain. Some ice, elevation of the legs with the player lying flat on his back, and loosening of his belt will invariably result in his being able to return to play. Check for inordinate swelling at once and after the game.

Lumbar Spine

Before the player is moved an immediate check should be made for ability to move the legs and for verbal response to skin sensation. This helps to determine whether he should be removed by stretcher or allowed to walk off the field. When pain subsides within a few minutes, allowing full movement of the back and ability to jog, the patient may return to play. However, every case must be taken on its own merits. Muscle spasm is a good guide to severity of the injury. Fractures are rare and usually limited to the transverse processes.

Hips

Limping in any high school boy from hip pain or pain in the front of the knee without any findings in the knee is immediate reason for complete stop of play. If any degree of pain continues or any limitation of motion in the hip or pain on movement of the hip, he should be put on crutches or sent by ambulance for immediate x-rays. At this age slipped femoral epiphysis must be foremost in mind. A hip pointer is due to direct hard contact along the crest of the ilium and results in subperiosteal hematoma which is extremely painful. It usually incapacitates and there is no question about not returning to play. A month or so is needed for recovery. Occasionally the epiphysis of the crest of the ilium is knocked off or fractured and this must be kept in mind.

Knees

Watch how the boy gets up from the field. Usually if he is unable, it is a sign of serious injury. Check for the mechanism of the injury. Test ligamentous stability by having the boy sit or lie in front of you with the knee almost extended; put the ankle between your legs to hold it, and then test medial and lateral stability of the joint by pushing on the outside and the inside of the knee with your hands. If the patient is lying down, hold the ankle in one hand and push against first the outside and then the inside of the knee. Any degree of instability particularly compared to the opposite is immediate reason for removal from the game. Test the cruciate ligaments by flexing the knee to 90 degrees, grasp the upper end of the tibia in the two hands and push and pull. Again it is helpful on all ligaments to compare them with the other side.

If the patella is dislocated, it will be at an odd angle usually to the lateral side. This can be easily reduced by hyperextending the knee and gently pushing the kneecap back into place. This always requires an x-ray for possible fracture and should be treated by a cast fixation. A knee that will neither extend or flex fully indicates torn cartilage and prevents further play. Immediate swelling and free fluid in the joint is reason to stop play. A knee can be hit and stretched a little bit with very severe pain and inability to walk. Over a period of a few minutes this pain may completely subside. If then all of the ligamentous stability is good and the pain is gone, and the boy can jog without pain, he can return to the game.

Contusions to the calf and to the thigh give severe pain and if no degree of swelling or progressive pain is noticed after a period of time, there is no reason for the boy not to continue play. If swelling occurs with progressive tightness of the thigh or the calf, then a vessel rupture with large hematoma formation is obvious and usually requires surgery. It may shut off circulation to the foot. Particularly important is the anterior compartment; a hematoma here can do severe damage if not relieved. When the boy is not permitted to play further, he should be examined before he goes home and instructed to report back if swelling and pain increase.

Ankles

Ruptured heel cords are obvious—the patient cannot walk and a defect is palpable in the tendon. Small ruptures usually at the musculotendonous junction about halfway up the calf can cause severe pain and frequently may be palpated in the muscle. Absence of plantar-flexion movement by the patient is characteristic. These injuries require immediate care. A sprained ankle usually prevents walking from the field; however, after rest, the pain may disappear; then with the ankle reinforced by tape the boy can return to play. Continuing pain and considerable swelling indicate the need for x-ray. Usually palpation locates the pain and gives a clue to the possibility of fracture.

Feet

The most common occurrence in the feet are blisters from improperly fitted shoes and socks. Tape directly over the reddened area is the best immediate preventive.

Shoulders

The most common problem in the shoulders is complete or partial separation of the AC joint. If the tenderness is over the distal end of the clavicle or if a deformity is present on the opposite side, diagnosis is easily made. With some tenderness, no deformity and gradually subsiding pain over a few minutes, none at full range of motion, he may return to play after a pad has been placed over the top of the shoulder. A dislocation can be found by palpating a defect underneath the acromion. Usually dislocations can be repositioned by traction on the arm abducted either straight out to the side or gradually bringing it out to the front. If done immediately, an anesthetic may not be necessary. An x-ray is indicated to make sure there is no fracture. Play is not allowed for two and a half weeks and then only with the arm supported at the side. Bruises on the humerus may become very painful and swollen and further play should not be allowed if these are extensive. They frequently result in myositis ossificans and should be followed by x-ray.

Elbows

A dislocation will be obvious and usually can be reduced on the field by traction with the elbow in the extended position then bringing it up into flexed position. Other injuries are rare and require x-ray.

Wrist

A deformity should be most obvious. If there is none, but rather marked tenderness over the lower end of the radius, snuffbox or carpal navicular, a fracture must be suspected and the boy should not play.

Fingers

Dislocations are usually obvious and an attempt should be made to reduce them by traction immediately. If the dislocation repositions easily, the finger can be firmly padded and taped and the player allowed to return to play; however, the injury must be x-rayed at the end of the game. If there is apparent fracture with deformity, the finger should be straightened by traction as much as possible and x-rayed immediately. Further play is not permitted. A mallet finger or avulsion of the extensor tendon to the distal phalanx is obvious by drooping and inability to extend the finger. It can be splinted in extension and the player allowed to play, but x-rays and further treatment are necessary immediately after the game.

Face

Lacerations over bony prominences, particularly when bleeding is a problem, may be sutured in the locker room as long as the wound is thoroughly cleaned and continued and close follow-up is possible. This is routinely done with professional players and I have not seen a complication, but the individual physician should make the decision. At the first sign of infection further treatment can be instituted. A sutured laceration will not prevent return to play. A bandage will not usually adhere to the wet skin.

Heat

In our climate heat becomes a problem. Advance arrangements should be made at a hospital and with an interested physician to institute immediate care. One hospital should receive all cases of heat prostration from all the teams for life may depend upon immediate adequately trained care. It is essential that players get enough water and salt in one form or other. After any prolonged run, the player should be brought off the field, made to sit down, covered with cool wet towels and made to drink and rest. If there is any increase in the pulse, or if he feels hot and appears pale, the temperature should be taken. If it is over 101, he should be sent for immediate treatment.

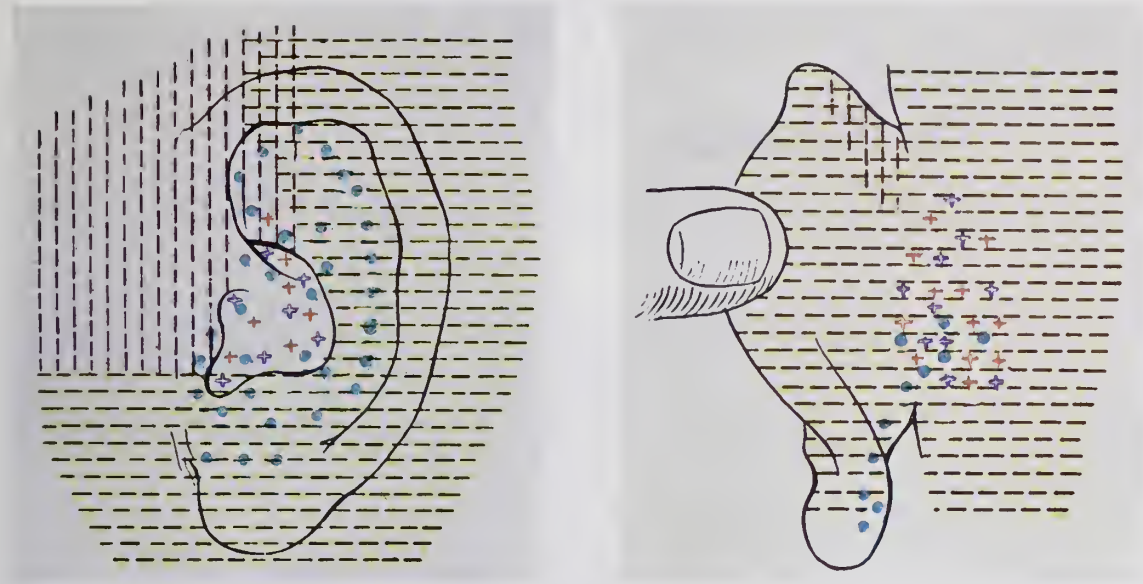
Finally, one of the greatest assets for all injuries is the immediate application of ice. Whereever applicable the patient should be sent home to use ice for at least 48 hours.

▶ Dr. Wallace, 1501 5th Avenue North, St. Petersburg 33705.

A friend follows you into adversity and emerges with you to prosperity.

Arthur B. Hays

Erratum



Figs. 1 and 2.—Cutaneous innervation of the ear on the lateral and posterior aspects. (From Hollinshead, W. H., Anatomy for Surgeons, vol. 1, The Head and Neck, Second Edition, New York, Hoeber Medical Division, Harper & Row, Inc.—1968). Color code adapted for nerve identity.

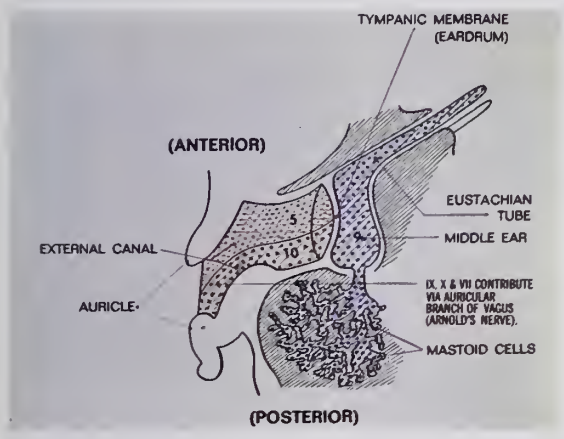
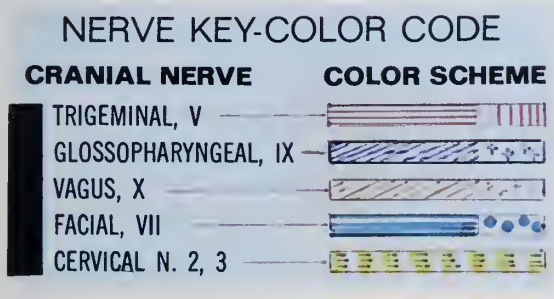


Fig. 3.—Sensory nerve distribution to the external auditory canal, tympanic membrane and middle ear (horizontal section diagram) (From Hollinshead, W. H., Anatomy for Surgeons, vol. 1, The Head and Neck, Second Edition, New York, Hoeber Medical Division, Harper & Row, Inc.—1968). Color code adapted for nerve identity.



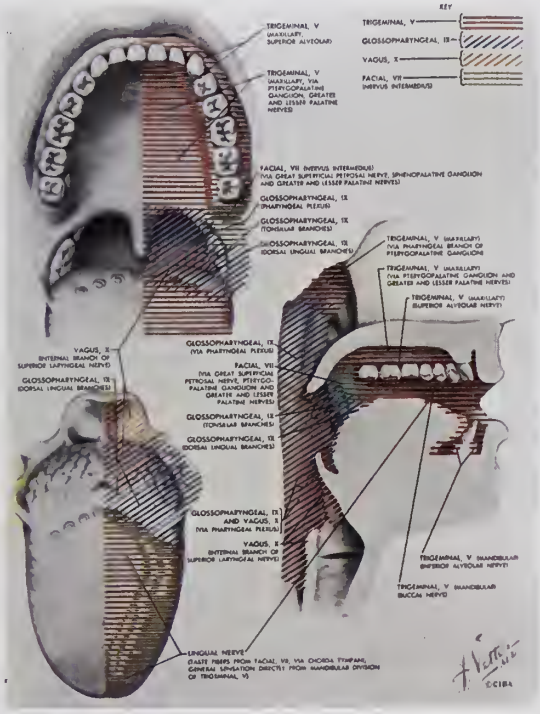
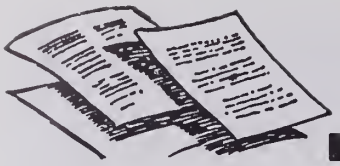


Fig. 4.—Diagram of approximate areas of sensory supply of the oral cavity, tongue and pharynx. Copyright 1959, CIBA Pharmaceutical Company, reproduced, with permission, from The CIBA Collection of Medical Illustrations by Frank H. Netter, M.D.

Editor's note: In the June JFMA the illustrations for "Referred Otalgia," by Paul L. Goethals, M.D. were run without color. To rectify this error, the illustrations for that paper are being reproduced in color with our humble apologies to Dr. Goethals.



Letters

Dear Editor:

Every year about this time we turn our atttention to the matter of mosquito-borne encephalitis. Rather sophisticated systems of surveillance are activated and physicians are asked to be especially watchful. For the latter we seek your help.

The following letter, prepared by Dr. Music of our staff, is forwarded for your consideration as a "Letter to the Editor." It is believed self-explanatory.

We shall appreciate any help in bringing the problem of a potential encephalitis outbreak and its prevention to the attention of Florida physicians.

E. Charlton Prather, M.D., Chief
Bureau of Preventable Disease
Division of Health
Jacksonville

Re: Arboviral Encephalitides and the Private Physician

Dear Editor:

Summer and unusually abundant recent rains have now combined to swell the ranks of mosquitoes and other disease vectors of man. Florida is a known repository for several of the encephalitis viruses transmissible through arthropod vectors* and past experience has shown that some human cases can be expected. Thus, it would seem wise to plan for interrupting the anticipated cycle of events before the endpoint of an encephalitis epidemic is reached.

At the first sign of arboviral activity, teams from the Division of Health will go into operation to knock down the mosquito population in any given locality. Three surveillance systems have been set up to detect arboviral activity:

1. *Vector trapping.* Light and other traps are used to collect mosquitoes. Pools of these are run through tissue culture systems for virus isolation.

2. *Sentinel animals.* Various animals known to be good hosts for one or more of the encephalitis viruses are placed strategically to maximize opportunities for contact with the vectors. Periodic bleeding of these sentinels are carried out for virus isolation as well as serologic evidence of arboviral infection.

3. *Human case surveillance.* Cases of human encephalitis will have blood and other appropriate tissue samples processed for evidence of arboviral infection.

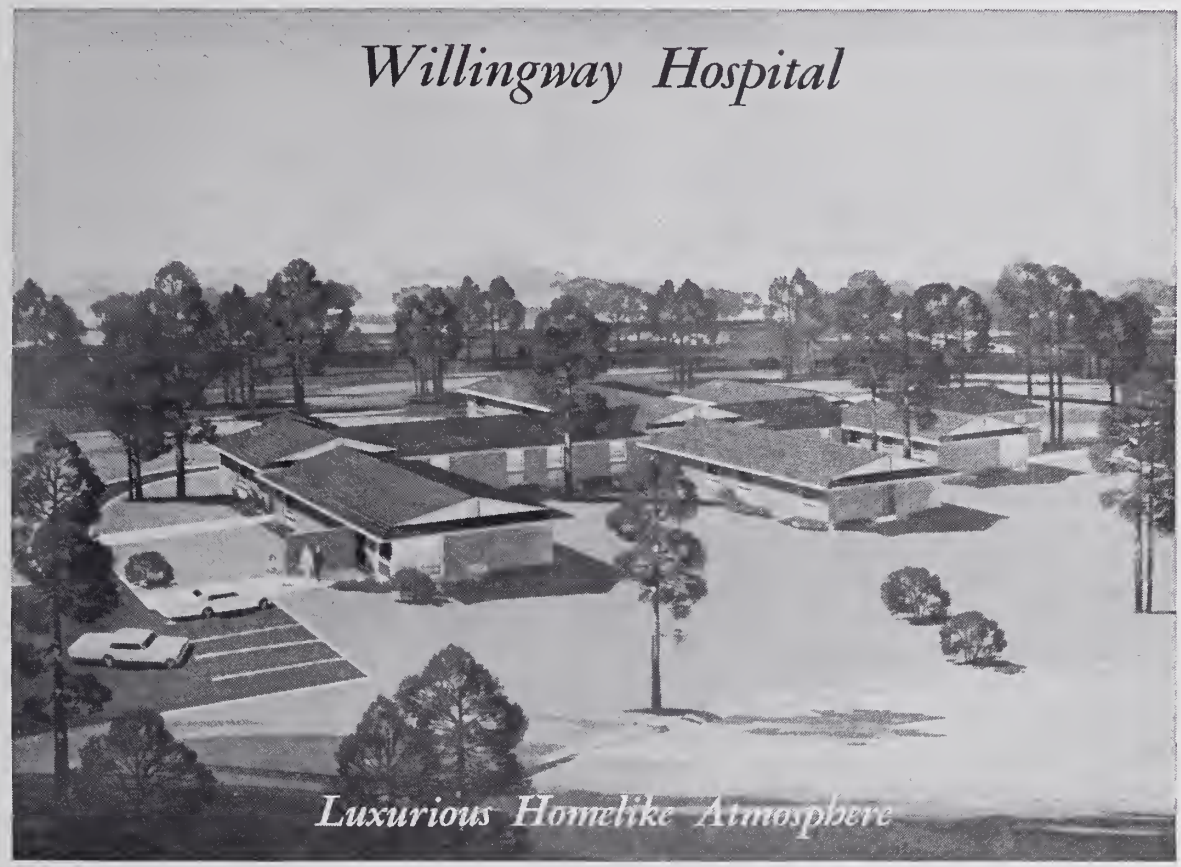
Of these three surveillance systems, the last one is the weakest link in our chain of defense. The Division of Health is totally dependent upon private practitioners and hospitals for the reporting of cases of human encephalitis. Only when cases are reported promptly can public health officials aid the clinician in the collection and processing of material to determine the etiology in any case of encephalitis. Though Florida law classifies encephalitis as a reportable disease many cases go unreported. We have had outbreaks of encephalitis in the past and we can expect them again unless our reporting habits change.

Physicians and hospitals are urged to notify the local county health department and/or the Division of Health directly *immediately* whenever human encephalitis develops. The need for such is urgent and the responsibilities are clearly defined.

Stanley Music, M.D.
Assistant State Epidemiologist
Division of Health
Jacksonville

*The viruses of the following encephalitides have been isolated in Florida: Eastern Equine, St. Louis, Venezuelan Equine, California, Western Equine, Bunyamwera-Group, Hart Park Group.

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Medical News

Nuclear Medicine Seminar

A one-day seminar on "Latest Technics and Developments in Nuclear Medicine" will be held on September 22 at the Self Memorial Hospital in Greenwood, S.C.

Sponsors are the hospital's Department of Radiology; the South East Chapter of the Society of Nuclear Medicine; the South Carolina Regional Medical Program; and the Division of Continuing Education of the Medical University of South Carolina. Registration fee is $15.00.

Information may be obtained from: Vince Moseley, M.D., Director of Continuing Education, Medical University of South Carolina, 80 Barre Street, Charleston, South Carolina 29401.

ACP Admits Eight Florida M.D.'s

Eight Florida physicians were among 266 doctors in the United States and Canada who recently were named Fellows of the American College of Physicians.

They are: Stanley Holzberg, M.D., Coral Gables; Harold Lynch, M.D., Delray Beach; Dale S. Ryon, M.D., Melbourne; Orlando Martelo, M.D.; Robert J. Myerburg, M.D., and Norman Spitzer, M.D., all of Miami; Gerald Bryant, M.D., Tallahassee; and Clement DeMasi, M.D., Venice.

Appointment at University of Florida

Dr. Howard K. Suzuki has been named Dean of the College of Health Related Professions at the University of Florida, succeeding Dr. Darrel J. Mase, who retired last year.

Dr. Suzuki joined the College as Associate Dean in 1970. The College trains occupational therapists, medical technologists, physical therapists, rehabilitation counselors and—on a cooperative basis with other colleges of the University—hospital administrators, clinical psychologists and speech and hearing specialists.

Seminar on Hypertension

A seminar on "Hypertension—Essential, Renal and Renal Vascular" will be held in Pensacola, Fla., October 27-28.

The Fifth Annual Cardiovascular Seminar is being sponsored by the West Florida Academy of Clinical Cardiology and the Pensacola Educational Program.

Information may be obtained by contacting J. W. Fleming, M.D., Project Cardiac Care, 1200 Leonard Street, Pensacola, Fla.

New ACC Governor

Thomas C. Dickinson, M.D., of Orlando, has been elected Florida Governor of the American College of Cardiology. He was chosen for a three-year term during a recent meeting in Bethesda, Md.

Three Florida physicians were granted Fellowship status during the meeting. They are Bernard Milloff, M.D., of Hollywood; and Salvatore DiGiorgi, M.D., and John W. Lister, M.D., both of Miami.

ACP Plans Florida Meetings

The Florida Regional Meeting of the American College of Physicians will be held at Disney World near Orlando, October 19-21.

Information may be obtained by contacting Chester Cassel, M.D., 1150 N.W. 14th Street, Miami, Fla. 33136.

ACP also announced a 1972-73 series of postgraduate courses, two of which will be held in Florida.

A session on "Advances in Therapeutics and Clinical Pharmacology" will be conducted at the University of Florida in Gainesville, October 9-11. "Modern Neurological Diagnosis and Therapy" will be explored at another course to be offered March 5-8, 1973, at the University of Miami School of Medicine.

Information about these and other courses may be obtained by contacting the ACP at 4200 Pine Street, Philadelphia, Pa. 19103.



Editorials

The Successful Physician

In a series of lectures at the National Conference on Human Values in Cancer sponsored by the American Cancer Society in Atlanta in June, the majority of speakers stressed the patient's need for hope, comfort, warmth and compassion. Over and over, it was expounded that the physician may not always be able to cure the person of cancer but he can always offer his understanding and skill as long as life exists. If he does this, in the eyes of the patient, he has not failed. Fortunate indeed, is the patient with a malignant disease who has a physician who prescribes therapy, either specific or nonspecific, curative or palliative, choosing appropriately among these, and who cares for the patient whether there is medical success or failure. Physicians who know their role well enough to accept it as a scientist and humanist, counselor and friend, will eventually become comfortable enough in treating cancer patients so as to successfully care for their patients to the very end. When a patient asks, "How long can I live?", the truthful answer is that he is not a statistic but a human being and he may be the very one who obtains a comfortable cure or a bearable long range survival. Many illnesses other than cancer are never cured and yet the patient lives with his disease in contentment. Even when the cancer patient has advanced disease, there are many things that can be done to give him a quality of survival that is priceless. It is not so much how long he lives but how long he lives with dignity and well-being and as a useful participant in his society. Unless the medical profession is more than adequate in offering consideration, hope, assurance, kindness, communication and time, patients will turn to the charlatan because these are just the human values that an imposter offers, yet these values can and should be offered in the office of every physician who aspires to the Oath of Hippocrates. Cancer may not always be curable but it is always treatable. With every human value and notion at hand, the patient, in no way, should ever be abandoned.

The terminal cancer patient wishes to leave his survivors the inheritance of an unscarred memory, a memory of himself as others have always known him or would like to see him again. This achievement is important to those who will remember him because their loss and grief will be less painful if their last association with the patient harmonizes with their better thoughts and feelings about him. Thus, the patient makes one final gift to those around him. This is his dignity in the face of death and his acceptance of death as an affirmation of life.

C.M.C.

Can't See the Forest for the Trees

A recent editorial in the Journal of the Medical Society of the District of Columbia started with two quotes:

"Everybody talkin' 'bout Jesus and Mary
Nobody talkin' 'bout Joe, poor Joe."[1]

"Everybody talkin' 'bout heroin and hash
Nobody talkin' 'bout booze."[2]

Because of my interest in alcoholism and other drug-related dependency problems, I reviewed this particular editorial with great interest. On the local level, Pinellas County, Florida, facts indicate that we have approximately 800 to 1,000 hard-core drug addicts or users. Furthermore, we know there are 18,000 known alcoholics and more developing every minute. I stress the fact—*Known Alcoholics.*

Alcoholism has been called the "silent sickness" for good reason. Not only is the alcoholic himself likely to be the last one to discover that he has the disease, but intimates, fellow-workers and family shield the individual for many reasons —none of them good.

My favorite mentors in medical school had a number of cliches, and a few follow:

"No man is so blind as he who will not see."[3]

"Our sins of omission far outweigh our sins of commission."[3]

"A high index of suspicion and careful observation are the prerequisites of a true physician."[4]

Alcoholism has long been considered by medical educators as a disease. Apparently, acceptance of definition and description by careful semantics takes much more time to filter down to the average practitioner. Many physicians still seem to subscribe to the school of thought that the alcoholic suffers a self-inflicted illness and can control his problem any time he really desires to do so, or, that he is a ne'er-do-well, a lush, a person who has no will power.

More recently laws (Baker Act) have been passed, soon to be implemented, which define the alcoholic as an ill individual. Our hospitals must anticipate the influx of great numbers of people who must be handled as medical problems rather than being refused admission and thrown into the "drunk tank" to sober up.

I am appalled that less time is spent in medical school instruction on the identification of the alcoholic in our society than is devoted to sex education. In recent years, there has been an upgrading of the status of sexual education and marital counseling in medical school curricula, yet the ancient classical discussion and description seems to hold true for the alcoholic individual. Most medical and surgical approaches to the treatment of alcoholism remain at the complicated and compound case level wherein possible permanent irreversible damage has been done to the heart, liver, kidney and brain. I point out that the institution of therapy at this time is counter-productive to our efforts.

Recently it has become fashionable to devote one's time and energies to handling the so-called "drug crisis epidemic." In spite of the interest and participation by many people in drug rehabilitation programs, I doubt that the importance of alcohol dependency in the overall drug abuse pattern is widely recognized.

I grant you that the ideal situation would be to have some handy laboratory procedure that could identify the individual with the propensity to alcoholism early in life. Some such test must be developed in the near future as most researchers feel some inherent or acquired biochemical or genetic propensity is present. At that point, the physician's responsibility will merely be to advise that individual to avoid alcohol such as one might advise a diabetic to avoid sugar.

Short of this, we now need to circulate some information or a program to the practicing physician to assist him in identifying the active alcoholic. Ideally this would be at some point in time where the physician's counsel and assistance may be beneficial in helping this individual curtail a habit that grows progressively worse with time. All practicing physicians, regardless of specialty, see patients who are alcoholics.

Every physician is capable of and should be treating the alcoholic patient. Currently, we are inundated by literature and circularized to refer our alcoholic problems to super-specialized pro-

grams in various parts of the country. I have no argument with these programs, but I have few alcoholic patients who can afford the prices charged for a four to six week inpatient intensive multipronged approach. We must, somehow, develop in the provider of primary medical care the capacity to recognize and treat this disease process. Each physician has an inherent responsibility to learn more about alcoholism itself rather than just the part he plays in treating the complications of this disease.

Today, more and more demands are being placed on physicians to practice preventive medicine. This would be ideal in the handling of alcoholics if we had some such test as mentioned above. Short of this, any disease process comes under control quicker (if control in fact is possible) the sooner the attending physician becomes aware of the presence of the disease and works with the patient so afflicted towards control. Alcoholism is a treatable, reversible and controllable disease. There is no reason for ignoring its presence. There is no justification for permitting so-called drug abuse programs to ignore the number one drug problem in America today—*Alcoholism.*

Behold what manner of men are these
Erudite, articulate espousers of compassionate philosophy
Preachers clinging to conservatism fervently
But ignoring, yea refusing to participate in alcoholism therapy
Methinks they do practice blatant hypocrisy.

THOMAS M. QUEHL, M.D.
ST. PETERSBURG

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Football Injuries

Elsewhere in this issue of the Journal of Florida Medical Association there appears an excellent article on football injuries. With increasing numbers of players participating, particularly in Pop Warner, Junior High, and High School football programs, more of us who ordinarily see little trauma will, of necessity, be involved. Articles such as this can be a great help to the "Novice Football Doctor."

In a study of football deaths prepared for the American Football Coaches Association, Dr. Carl Blyth of the University of North Carolina found that in 1971 there were 27 deaths in high school and college football. Eighteen of these were directly related to trauma, and sixteen of the eighteen were directly related to trauma of the head and neck. It is also interesting that four of the nine nontrauma deaths were due to heat stroke. The total of 27 deaths represented a rate of 1.41 deaths per 100,000 participants. Compared with automobile driving this is a remarkably safe sport. (56 deaths per 100,000 drivers).

What is needed at present in scholastic sports, particularly high school football, is a thorough and prospective study of injuries with regard to their incidence, types, treatment, and their short and long term morbidity. This would give us a basis on which to plan training programs, and to prevent long term disability. Perhaps this would be a good joint project for the American Football Coaches Association and the American College of Sports Medicine.

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IMPORTANT NOTE: *In vitro* sulfonamide sensitivity tests are not always reliable. The test must be carefully correlated with bacteriologic and clinical response. When a patient is already taking sulfonamides, follow-up cultures should have aminobenzoic acid added to the culture medium. Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of antibacterial agents including the sulfonamides, especially in the treatment of chronic and recurrent urinary tract infections.

Free sulfonamide blood levels should be measured in patients receiving sulfonamides for serious infections since there may be wide variations with identical doses; 20 mg/100 ml should be maximum total sulfonamide level as adverse reactions occur more frequently above this level.

Contraindications: Hypersensitivity to sulfonamides, infants less than 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis), pregnancy at term, and during the nursing period.

Warnings: Safety of sulfonamides in *pregnancy* has not been established. Sulfonamides will not eradicate group A streptococci. Deaths associated with sulfonamide administration have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Clinical signs such as sore throat, fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts and urinalyses with careful microscopic examination should be performed frequently during sulfonamide therapy.

Precautions: Use with caution when impaired renal or hepatic function, severe allergy or bronchial asthma is present. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis (frequently a dose-related reaction) may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias:* Agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia, methemoglobinemia. *Allergic reactions:* Erythema multiforme (Stevens-Johnson syndrome), generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia, allergic myocarditis. *Gastrointestinal reactions:* Nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis, stomatitis. *C.N.S. reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, somnia. *Miscellaneous reactions:* Drug fever, chills, renal nephrosis with oliguria and anuria. Periarteritis nodosa and L.E. phenomenon have occurred with sulfonamide therapy. Sulfonamides bear certain chemical similarity to some goitrogens, diuretics and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents.

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Dean's Page

A Partnership in Education

Herbert E. Kaufman, M.D.

In medical education, a new era of joint effort is developing between practicing physicians, community hospitals, the Veterans Administration, medical schools and their faculty. This emerging partnership is at all levels from college student to senior physician and promises revolutionary new and mutually rewarding roles for the private practitioner, medical school and faculty, and hospital and staff.

At one time, most medical education was provided almost exclusively by physicians engaged in full time private practice. As the demands of private practice grew, however, an additional mechanism for educating medical students was needed. To alleviate this situation, a full time teaching faculty began to assume more and more of the educational role once held by private practitioners.

This faculty-oriented training program was not optimal. While it provided for student exposure to a high degree of specialization, it did not utilize the enormous clinical experience of practicing physicians which was sorely needed to complete a well rounded training program. In addition, this separation removed an important contact for intellectual stimulation and postgraduate education at a time when the scientific base of medical knowledge was growing rapidly. Another consequence was that after finishing their training, students tended to choose highly specialized careers and settle in urban areas where medical schools and teaching hospitals were located.

Happily, this trend is undergoing rapid modification with abundant benefits for both pre and postgraduate physicians. Medical schools, such as the one at the University of Florida increasingly recognize the responsibility they have to the entire State as well as their local community, and the care of referral patients which require the specialized care and facilities their institutions provide. To help satisfy the needs of the State as a whole, academic programs should insure that medical students will be exposed to the practice of medicine in various geographic and economic areas of the State, thereby encouraging them after graduation to join forces with established physicians to provide health care for all Florida's citizens.

With the goal of a partnership educational program, the University of Florida's medical school has initiated several joint student, and postgraduate training programs. For example, in 1964, at the request of local physicians, the Department of Ophthalmology extended its residency program to include a 6 months rotation at the Duval Medical Center (currently University Hospital) in Jacksonville. The expertise and conscientious instruction of the practicing physicians greatly increased the depth and breadth of the student's education. Other graduate and postgraduate training programs developed along similar lines. In some specialty areas there were formal meetings with lecturers in specific areas presenting new developments in their field, and other university and community colleagues with different types of experience met informally to discuss special patient problems and share their varied knowledge for the patient's benefit and their own instruction.

This fruitful exchange was further expanded as the Jacksonville Health Education Program became formalized and medical students began to be exchanged with Jacksonville, Tallahassee, and to some extent Pensacola. Students and house officers began to gain experience with rural medi-

Dr. Kaufman is Acting Dean, University of Florida College of Medicine, Gainesville.

cine and family medicine in clinics such as Mayo, and Trenton, Florida. The major emphasis to this partnership in education, and to the restoration of practicing physicians to their important position in medical education may be further increased by the Florida Medical Association's recognition and requirement for postgraduate education, such as has already been adopted by the American Academy of General Practice and others. Further support has come from federal recognition of the necessity for area health centers to provide education to the public, medical students, health professionals of all sorts, and physicians in practice. These will be further strengthened by the Veterans Administration's outreach programs to extend beyond veterans hospitals alone to help meet the broad needs of veterans throughout the State. With this, the Veterans Administration commits itself to stimulate our education at all levels and help upgrade all of medicine. As recognition of these growing needs, community hospital educational funding to be provided by the State can add crucial stability to the partnership programs.

The resources mentioned should help encourage a greater partnership between the faculty of colleges of medicine, and the practice of medicine in communities of all sizes. Medical students and house officers need to be exposed to the problems and opportunities of all types of communities. If, however, the medical school faculty is to have the benefit of the practical expertise in the community of the physician-practitioner and if the practitioner is to benefit from exchanges of information with the medical school faculty, some additional commitment of resources to medical postgraduate education at all levels will be necessary. Such a commitment would develop an increasingly valuable liaison which could only benefit all.

▶ Dr. Kaufman, University of Florida College of Medicine, Gainesville 32601.

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Warnings: Use during pregnancy is to be avoided.
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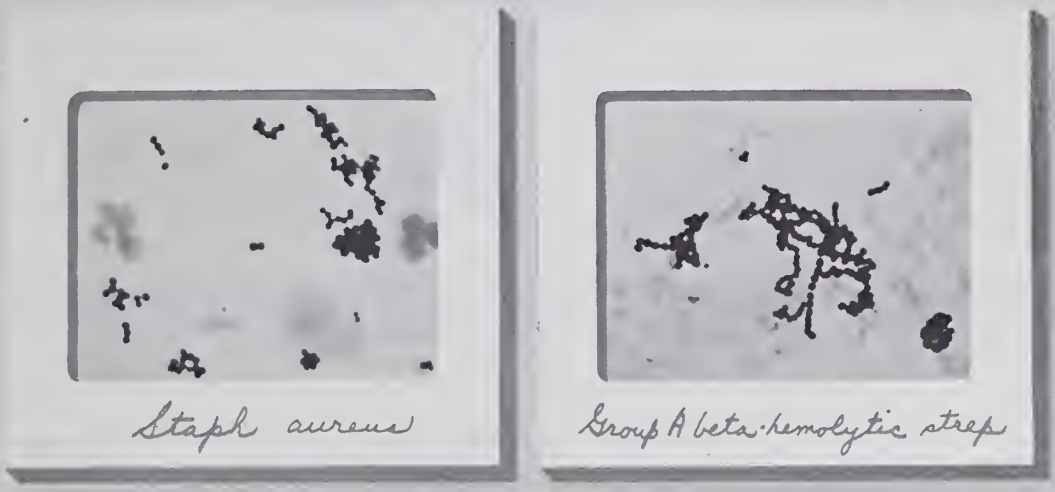
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To combat these infections efficiently, your antibiotic should be effective against both staph *and* strep—whether they occur alone or in combination.

Yet many antibiotics—such as ampicillin and penicillin G and V—are ineffective against the increasingly prevalent penicillinase-producing strains of *S. aureus.* And others, like the tetracyclines, are often ineffective against either staph or strep.

Cleocin HCl (clindamycin HCl hydrate, Upjohn) is one antibiotic that has proved effective against both Group A beta-hemolytic streptococci* and penicillinase-producing *S. aureus.*

A recent comparison of clindamycin and penicillin V was conducted in 151 pediatric patients with impetigo. In the 147 patients who completed the study, clindamycin achieved a 92% bacteriological and clinical cure rate (68 of 74 patients) as opposed to only 72% (53 of 73 patients) for penicillin V.[2] Of the staphylococcal organisms isolated, 27% were found to be penicillin resistant; these patients were placed in the clindamycin group.

In multiple clinical studies of clindamycin in skin and soft tissue infections, including abscesses, wounds, cellulitis, furunculosis and impetigo, the causative organisms—whether staph or strep or both—were eradicated in 326 of 333 patients from whom follow-up cultures were obtained. Clinical resolution of the infection was achieved in 367 of 377 patients (97%).[3] Significantly, among those with superficial skin and soft tissue infections, mixed staph and strep were found in 29% of 174 patients from whom cultures were obtained.

In clinical usage, mild to moderate morbilliform skin rashes have been the most frequently recorded side effects, and rare instances of erythema multiforme have been observed. Transient neutropenia (leukopenia) and eosinophilia have been reported. Rare reports of agranulocytosis and thrombocytopenia have been made. No direct etiologic relationship to concurrent clindamycin HCl therapy could be made in any of the foregoing.

There have also been recent reports of cases of severe and persistent diarrhea necessitating drug discontinuance. This diarrhea has been occasionally associated with blood and mucus in the stools, and acute colitis.

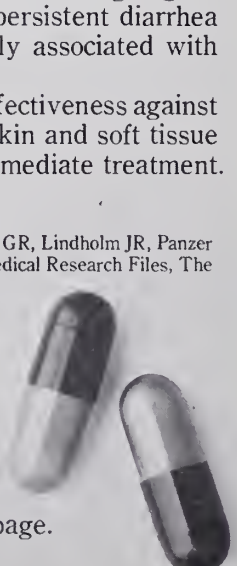
In summary, Cleocin is a potent antibiotic. Because of its dual effectiveness against staph and strep—the two most commonly encountered pathogens in skin and soft tissue infections—Cleocin may prove valuable in such infections requiring immediate treatment.

*With beta-hemolytic streptococcal infections, treatment should continue for at least 10 days.

References: 1. Conn HF (ed): *Current Therapy,* Philadelphia: WB Saunders Co, 1969, p 647. 2. Brown GR, Lindholm JR, Panzer JD, et al: Systemic therapy of impetigo. Manuscript submitted for publication. 3. Data on file, Medical Research Files, The Upjohn Company.

Cleocin® 150 mg capsules **HCl**

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For further prescribing information, please see following page.

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...for staph, or strep, or both

Clinical and bacteriologic responses of patients with skin and soft tissue infections treated by 55 investigators with Cleocin HCl (clindamycin HCl hydrate, Upjohn)*

Infection	No. of Patients	Pathogens	Clinical Response: Excel. or Good (%)	Clinical Response: Poor (%)	Bacteriologic Response: No. of Pts. Evaluatable	Bacteriologic Response: Organisms Eradicated (%)
Abscesses, wounds, & furuncles	156	*S. aureus* – 107 staph, other – 12 β-strep – 10	151 (97%)	5 (3%)	129	126 (98%)
Cellulitis	38	*S. aureus* – 21 staph, other – 1 β-strep – 8	38 (100%)	–	30	30 (100%)
Superficial skin & soft tissue – mostly impetigo	183	*S. aureus* – 41 Mixed β-strep & staph – 51 staph, other – 1 β-strep (74 Group A) – 81	178 (97%)	5 (3%)	174	170 (98%)
Total	377	———	367 (97%)	10 (3%)	333	326 (98%)

*Data on file, Medical Research Files, The Upjohn Company.
Note: With β-hemolytic streptococcal infections, treatment should continue for at least 10 days.

Each preparation contains:	Clindamycin HCl hydrate equivalent to clindamycin base
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Cleocin (clindamycin) is a new semisynthetic antibiotic produced from the parent compound lincomycin and provides more *in vitro* potency, better oral absorption and fewer gastrointestinal side effects than the parent compound.

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CONTRAINDICATIONS: This drug is contraindicated in individuals with a history of hypersensitivity to preparations containing clindamycin or lincomycin.

WARNINGS: **Cases of severe and persistent diarrhea have been reported and have at times necessitated discontinuance of the drug. This diarrhea has been occasionally associated with blood and mucus in the stools and has at times resulted in an acute colitis.**

Usage in pregnancy: Safety for use in pregnancy has not been established.

Use in the newborn: Until further clinical experience is obtained, Cleocin HCl (clindamycin HCl hydrate) is not indicated in the newborn (infants below 30 days of age).

PRECAUTIONS: Prescribe with caution in atopic individuals. During prolonged therapy, periodic liver and kidney function tests and blood counts should be performed. The use of Cleocin occasionally results in overgrowth of nonsusceptible organisms – particularly yeasts. Should superinfections occur, appropriate measures should be taken as indicated by the clinical situation.

ADVERSE REACTIONS: *Gastrointestinal:* Abdominal pain, nausea, vomiting and diarrhea, or loose stools may occur. Cases of severe diarrhea associated with blood and mucus in the stools have been reported (see "Warnings").

Skin and Mucous Membranes: Generalized mild to moderate morbilliform-like skin rashes are the most frequently reported of all adverse reactions. Other skin reactions, including urticaria, are of less frequent occurrence. Rare instances of erythema multiforme have been reported.

Hypersensitivity Reactions: A few cases of anaphylactoid reactions have been reported. If such a reaction occurs the drug should be discontinued. The usual agents (epinephrine, corticosteroids, antihistamines) should be available for emergency treatment of serious reactions.

Liver: Jaundice and transient abnormalities in liver function tests (elevations of alkaline phosphatase and serum transaminase) have been observed during Cleocin (clindamycin) therapy.

Hematopoietic: Transient neutropenia (leukopenia) and eosinophilia have been reported; relationship to therapy is unknown. No irreversible hematologic toxicity has been reported.

DOSAGE AND ADMINISTRATION: *Adults:* Mild to moderately severe infections – 150 to 300 mg every 6 hours. Severe infections – 300 to 450 mg every 6 hours.

Children: Mild to moderately severe infections – 8 to 16 mg/kg/day (4 to 8 mg/lb/day) divided into three or four equal doses. Severe infections – 16 to 20 mg/kg/day (8 to 10 mg/lb/day) divided into three or four equal doses.

Note: With β-hemolytic streptococcal infections, treatment should continue for at least 10 days to diminish the likelihood of subsequent rheumatic fever or glomerulonephritis.

HOW SUPPLIED: Cleocin HCl (clindamycin HCl hydrate) is available as: *150 mg Capsules* – Bottles of 16's and 100's. *75 mg Capsules* – Bottles of 16's and 100's. *Susceptibility Disks* – 2 μg. *Susceptibility Powder* – Vials.

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George S. Palmer, M.D.
Executive Director

PLAN TO ATTEND THE 99TH ANNUAL MEETING OF THE FLORIDA MEDICAL ASSOCIATION MAY 9-13, 1973—BAL HARBOUR



Insurance and Doctors

Samuel M. Day, M.D.

It becomes imperative now, that doctors individually and through review committees, collectively, view insurance matters realistically. Most insurance companies and some government programs have attempted to be as fair, actuarily as possible in these matters, BUT a few patients, a few insurance companies, and a few physicians, through ignorance, greed or compassion, have taken advantage of every situation possible and have made administrations difficult and costly. A few physicians, some politicians and "much" of the public have become aroused. It is no longer a family affair as the recent verdict in Pennsylvania requiring the physician to pay the bill for a patient's diagnostic admission can attest. Although it is being appealed and the AMA has joined the appeal, more similar actions will be forthcoming. The reasoning behind that legal action was that as services have been rendered and incurred, it must be paid by someone. And if the insurance company or government is not contractually liable, the patient not financially able, and the hospital not morally responsible, is it surprising someone has been so long in charging the doctor who is considered "Captain of the Ship"? We hope the verdict will be overturned—BUT WE MUST WAKE UP.

Many times, as physicians, we are confronted with patients who need, request, or demánd diagnostic studies but are unable or unwilling to pay for them. It can present a genuine problem of compassion, yet when the disease does not require hospitalization for treatment, let us not be seduced into compounding the problem by admitting patients to a hospital for diagnostic studies. Some government and some insurance coverage now realize their responsibility to these patients by paying for "tests" on an outpatient basis while refusing to pay for "unnecessary" hospitalization or medical care. This, too, can be abused. Let us not fall into the trap of ordering unnecessary treatment to disguise the primary purpose for admission which can be easily exposed by alert utilization studies. When alleged periods of hospitalizations prove to be DIAGNOSTIC ADMISSIONS or CUSTODIAL CARES and are rejected for that reason, consternation and embarrassment develop for all concerned.

Paramount to successful insurance programs is sound financing, yet, somehow third parties have not been able to impress physicians that this is buttressed on the physician doing a fair and conscientious job. Unless subsidies from government (taxpayers) are sought, all insurance services basically are paid for by premiums from subscribers. When "demand" items, such as diagnostic studies, treatment of cosmetic, psychiatric, or pre-existing conditions are covered, astronomical premiums are mandatory—and few people can or will pay them. Numerous efforts have been made to pay a fair usual and customary fee, to expand services, and to simplify claims reporting but always these seem to be met with new subterfuges on the part of a selfish few to circumvent the safeguards.

Although most review committees do a fine job it is unfortunate that some physicians are appointed because of prestige, popularity or because they have an axe to grind with insurance rather than because of their knowledge, open mindness or judgment. *The time is short for review committees to prove their nonpartisanship as well as their decisiveness.* Already Congress may have gone too far to turn back in placing these matters under lay control. Patients and physicians will suffer if that results.

Although pleading for cooperation, this editorial is not to imply approval of ALL government actions in our field. Abhorred is the 2.5% limitation on fee increases which is discriminatory. Disliked is the requirement for posting signs regarding fixed fees but the continuing rise in the cost of living does involve everyone and everyone should make an effort to halt inflationary spirals. It is the law of the land and we must comply until it is changed by legal process. The withholding of ALL Medicare payments for physicians undergoing peer review was too severe. Because it was unreasonable, organized medicine and Blue Shield were able to have it set aside. Last, but not least, is resented the BLAME placed on the physician for all increases in the cost of medical care. Prior to Medicare being enacted such costs were repeatedly predicted and valid reasons were given why they would be forthcoming.

At a time when cohesiveness is necessary for wise compromise with enemies of fee-for-service medicine, medicine finds itself more divided than ever. This is an integral part of well laid plans for our downfall. *Let's regroup, stop "back biting," be honest, be fair, back the AMA, Blue Shield and other insurance companies, accept our responsibilities for medical care at reasonable fees, and INSURE CONTINUATION OF OUR FREEDOM.*

▶ Dr. Day, 1503 Oak Street, Jacksonville 32204.

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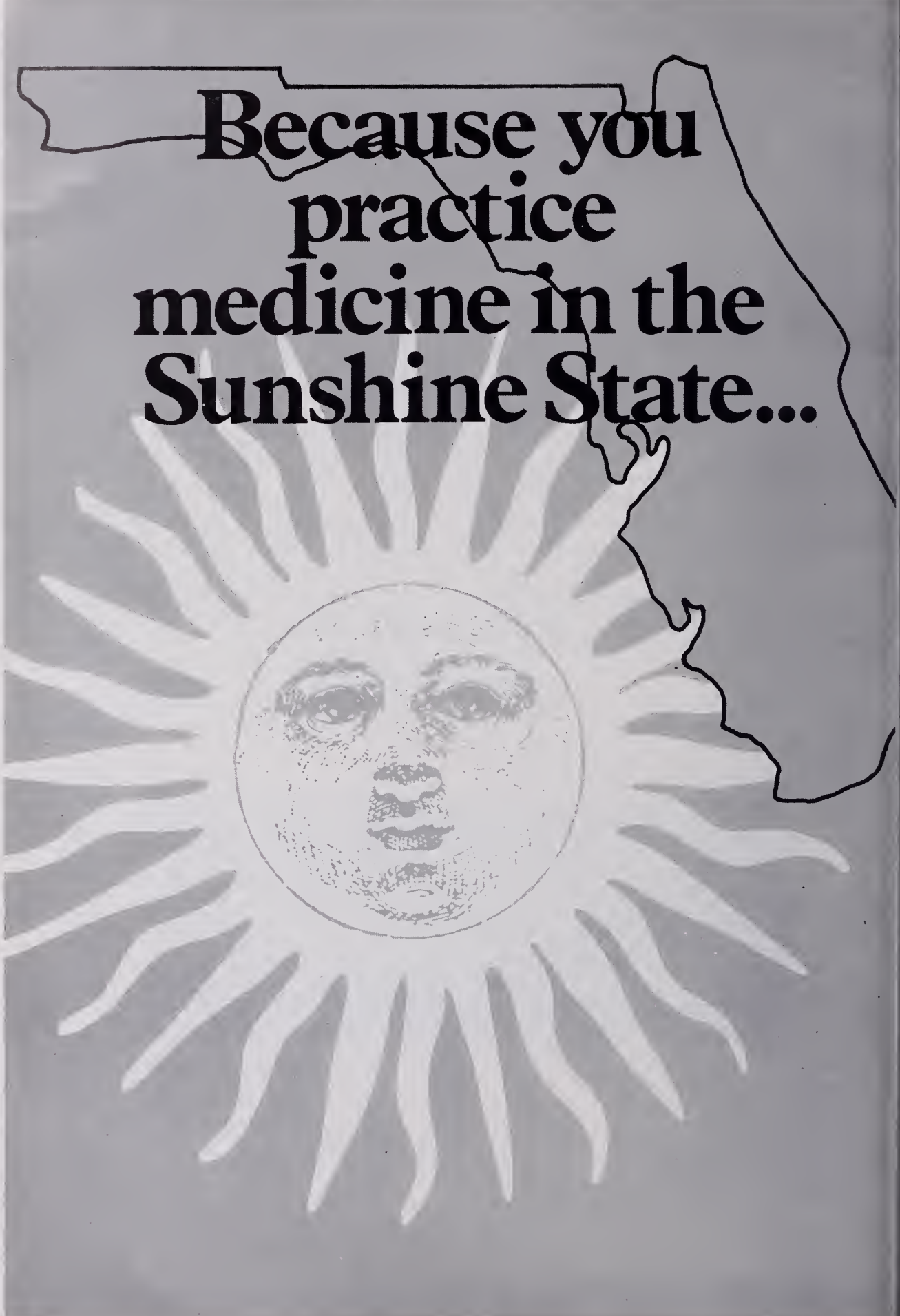


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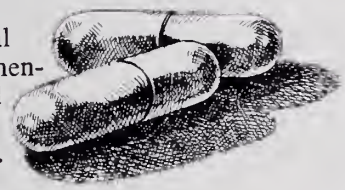
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Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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MEETINGS

Approved by FMA Committee on Continuing Education

SEPTEMBER

4- 9 Course of Instruction in Coronary Care for the Practicing Physician, Jackson Memorial Hospital, Miami. For information: Louis Lemberg, M.D., U. of Miami School of Medicine, Box 875, Biscayne Annex, Miami 33152.

14-16 Medical Care Problems in the Surgical Patient, Mount Sinai Hospital, Miami Beach, For information: Frances Richardson, 4300 Alton Road, Miami Beach 33140.

21-24 Emergency Medical Systems—National Symposiums, by University of Florida College of Medicine, Contemporary Hotel, Disneyland at Orlando. For information: Lamar Crevasse, M.D., Box 758, J. Hillis-Miller Health Center, Gainesville 32601.

OCTOBER

16-20 Current Problems in the Therapy of Patients with Coronary Artery Disease, Mount Sinai Hospital, Miami Beach. For information: Frances Richardson, 4300 Alton Road, Miami Beach 33140.

16-21 Course of Instruction in Coronary Care for the Practicing Physician, Jackson Memorial Hospital, Miami. For information: Louis Lemberg, M.D., U. of Miami School of Medicine, Box 875, Biscayne Annex, Miami 33152.

NOVEMBER

3 Lymphoma-Leukemia for Physicians, Manger Hotel, Tampa. For information: John Carbonneau, 1001 S. MacDill Ave., Tampa 33609.

DECEMBER

8-10 "The Spinal Cord Injured Patient," from the Department of Orthopaedics and Rehabilitation, University of Miami School of Medicine, Americana Hotel, Miami Beach. For information: Augusto Sarmiento, M.D., Box 875, Biscayne Annex, Miami 33152.

13-15 Twelfth Biennial Cardiovascular Seminar—"Complications of Myocardial Infarction," Doral Hotel, Miami Beach. For information: Marvin L. Meitus, M.D., 5080 Biscayne Blvd., Miami 33137.

National and Regional Meetings Held in Florida

NOVEMBER

2- 4 International Conference on Trichinellosis, Sheraton-Four Ambassadors Hotel, Miami. Sec.: W. C. Campbell, Ph.D., Merck Institute, Rahway, N. J. 07065.

2- 6 Association of American Medical Colleges, Fontainebleau Hotel, Miami Beach. Pres.: John A. D. Cooper, M.D., 1 Dupont Circle, Washington, D. C. 20036.

6-10 American Society of Tropical Medicine and Hygiene, Deauville Hotel, Miami Beach. Sec.-Treas.: George R. Healy, Ph.D., P.O. Box 15208, Emory University Branch, Atlanta, Ga. 30333.

19-22 Pan American Medical Association, Deauville Hotel, Miami Beach. Dir. Gen.: Joseph J. Eller, M.D., 745 5th Avenue, New York 10022.



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CLINICAL BRIEFS

Therapy of Amebiasis

Steven Bernstein, M.D.

When the paths of Homo sapiens and Entameba histolytica cross, the larger animal sometimes comes off second best. Amebiasis comprises a spectrum including asymptomatic intestinal infestation, amebic dysentery, amebic colitis and extracolonic amebiasis, notably of the liver and lung, often with abscess formation. All but the asymptomatic form may be fatal; thus effective treatment is vital. Therapy includes drugs, surgical procedures and closed needle aspiration of abscesses. I will consider these in order and outline rational approaches to the therapy of each of the forms of amebiasis.

Drugs

Cursory review of the recent English language literature reveals nearly 30 different drugs used to treat amebiasis and this is strong evidence that no ideal treatment yet exists. I will discuss only a handful of these which seem to have an established place in therapy in this country; a comprehensive review is available.[1]

Emetine was the first antiamebic drug introduced and has been in use since 1912. It is an alkaloid derived from plants, it must be given parenterally, and it is toxic. Nonetheless until recently it was the nonpareil of amebicides, especially for tissue amebiasis. Because of parenteral administration it penetrated to the bowel lumen poorly and only 30-50% of cases of amebic dysentery could be cured. Its use in amebiasis of the bowel wall, liver and other extracolonic sites was marred by cardiotoxicity, hypotension and vomiting; ECG abnormalities developed in nearly 40% of patients and cardiac disease contraindicates its use. The usual dose is 1 mg./kg./day for 10 days with no more than 65 mg. per day allowed.

Because of the toxicity of emetine, derivatives were synthesized; the most successful of these was dehydroemetine (DHE), which is usually available as racemic DHE. It has been demonstrated that it is the levo-DHE, like levo-emetine, which is active. While 30% of patients will show ECG changes, these tend to be transient, and serious myocardial damage is unusual. Also, an oral form of DHE has been successfully used; this form, in dosages of 3-4 mg./kg./day, is most useful in dysentery. Interestingly, when oral and parenteral DHE were compared, 73% of patients responded to the oral form compared with 59% to injected DHE. The incidence of severe side effects was the same but the oral form had 34% mild side reactions compared to 23% parenterally.[2]

Dissatisfaction with emetine and its derivatives led to trials of niridazole, trade name Ambilhar. This orally active agent in doses of 25-30 mg./kg./day produced excellent clinical results, curing 80% of dysenterics and was considered superior to the combination of DHE and chloroquine.[3] Unfortunately nearly 60% of patients showed ECG abnormalities while under therapy and 5% developed major psychoses. Despite this the 95%+ cure rate for amebic liver abscesses made it a formidable addition to the list of amebicides.

Probably the most promising drug, however, is a relative of niridazole, namely metronidazole, or Flagyl. This drug, first used against T. vaginalis, is active in the gut lumen, gut wall and tissues, is virtually nontoxic and boasts cure rates as high or higher than any other drug or combination of drugs. One major difficulty has been determining the ideal dosage schedule. It is clear that larger doses are necessary in intestinal disease than in liver abscess because of efficient absorption from the proximal gut. A bewildering variety of dosage schedules has been advocated; my impression is that while a somewhat lower dose might be possible one can hardly go wrong with 800 mg. t.i.d. for 7 days. Powell has advocated a single dose of 2.4 Gm. for abscesses and 2.4 Gm. daily for two days for intestinal amebiasis and his

cure rates are impressive. Others, however, have found that such large doses cause inordinate nausea and vomiting and urge the 800 mg. t.i.d. regimen as equally effective and kinder to the stomach. We may comfortably sit back and await the final word on this since Flagyl is not yet approved for use in amebiasis in the United States.

An even newer drug is MK 910, a derivative of Flagyl, which has had limited clinical trials with encouraging results.[4]

A variety of other drugs remain useful in therapy of amebiasis. Especially to be remembered are tetracycline (oxytetracycline is the most active amebicide) which can effect cure of amebic dysentery in 97% of cases; Diodoquin which is widely used for prophylaxis and as part of combination therapy (vide infra), and chloroquine which alone can cure 70% of amebic abscesses, this percentage increasing to 99% when emetine is added.

Surgical Therapy

Operative intervention is most frequently used in the treatment of amebic liver abscesses but it has a part also in the management of severe amebic colitis. Formerly, either needle aspiration or open drainage of amebic abscesses was considered an indispensable therapeutic maneuver; it is still indicated in cases which fail to respond or which have very large abscess cavities. However, the widespread application of liver scintiscanning has led to earlier diagnosis of space-occupying hepatic lesions and current consensus advises a therapeutic trial of amebicidal therapy with serial scans, and without either diagnostic or therapeutic aspiration of the abscess. Several recent reports have emphasized the high incidence of superinfection of amebic abscesses with pyogenic organisms; this must be considered in any patient whose "amebic" abscess fails to resolve with adequate therapy.

Emergency laparotomy may be lifesaving in patients with severe amebic colitis and toxic megacolon, gangrenous bowel, or perforations. The mortality of amebic colitis is roughly 3% and it is suggested that this figure could be reduced by timely operative intervention in selected patients.

Therapeutic Regimens

There is no unanimity concerning optimum therapy of amebic infections; the regimens here presented seem to me to be reasonable, based on present studies of toxicity and success rates.

Asymptomatic cyst-passers: Tetracycline 250 mg. q.i.d., x 10
Flagyl 800 mg. t.i.d. x 5-7

Amebic dysentery: DHE 2 mg./kg./day + TCN 250 mg. q.i.d. + Diodoquin 650 mg. t.i.d. x 10
Flagyl 800 mg. t.i.d. x 5

Amebic abscess: DHE + Diodoquin (as above) + chloroquine 250 mg. b.i.d.
Flagyl 2400 mg./day x 3
Chloroquine 250 mg. b.i.d. x 70

References

1. Kasliwal, R. M. et al: Management of Amoebiasis, Am. J. Proc. 19:417-421, 1968.
2. Wolfensberger, H. R.: Amoebiasis Clinical Trials of Dehydroemetine Late-Release Tablets (Ro 1-9334-20) Compared with Parenteral Dehydroemetine and Niridazole, Trans. Royal Soc. Trop. Med. Hyg. 62:831-837, 1968.
3. Jarumilita, R. et al: Comparative Study of Effects of Ambilhar and Combination of Dehydroemetine and Chloroquine in Amoebic Liver Abscess, Ann. N. Y. Acad. Sci. 160:767-774, 1969.
4. Chari, M. V. and Gadiyar, B. N.: New Drug (MK-910) in Therapy of Intestinal and Hepatic Amebiasis. First Results of Clinical Trial, Am. J. Trop. Med. Hyg. 19:926-928, 1970.

Dr. Bernstein, University of Miami School of Medicine, Division of Gastroenterology, Box 875, Biscayne Annex, Miami 33152.

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Woman's Auxiliary

The Drug Problem – And You!

Mrs. Linus W. Hewit

"Drug Abuse is America's public enemy Number One!" So stated the President of the United States.

Its main victims are the young, but abuse is also occurring, with increasing frequency, at all age levels. With it goes a great increase in crime, for the use and abuse of drugs is an expensive habit and the addict will stop at nothing to meet the ever increasing needs of his sick mind and body. So far reaching is this menace to mankind that it is now invading our elementary-aged school children. Its impact cuts across all social and economic lines in our country.

The American Medical Association and the Woman's Auxiliary are taking a lead in an intensive public education program to reach all persons. Their prepared material is designed to fit into the program but it is not the total answer. The answer is you!

Parents, teachers, students and citizens, in general, must know the facts about drugs, the differences in them, and what they can do, and not do, to a person. The drug problem is a changing phenomenon and requires continuous research and study. We must learn how to determine if a person is using drugs. This is difficult and requires caution. The suspect may be ill, or have some other problem that is making him react as he is. As symptoms can be misleading, it might be wise to seek the help of a physician. False accusation by a teacher or parent can be extremely harmful.

This report is for your use in presenting a program for public education or to help you determine the needs of your own community. We urge you to involve as many community groups and agencies as possible. It is only by greater concern, awareness and cooperation that we can make great strides in wiping out this menace to society. The program we are using, as an example, has been widely acclaimed, publicized and studied as one of the most effective in the nation. We tell it like it was presented to us, when Eugene Nixon, FMA Staff, Jacksonville, Daniel Seckinger, M.D., of Dade County and I toured the CODAC facilities in Phoenix, Arizona.

This, then, is the story of CODAC. It happened because somebody cared, and cared enough to do something about it. That is what took place in Maricopa County, Arizona in 1969. A group of doctors discovered a marked increase in drug users—mostly among the young. Day after day they saw young men and women who had become "hooked" and needed help, but they, the average physician, knew little about how to treat these young addicts, some of whom they had delivered and cared for all of their lives. The number increased at an alarming rate, so several members of the Maricopa County Medical Society decided action was needed. They called a meeting of doctors, their wives and their teenage children. The auditorium was crowded with 500 persons.

A heavy curtain fell over the stage. The presiding officer explained that the curtain blocked from view a number of drug users, all young people from the community, who would speak during the evening. They would tell of their problems with drugs and their need for help. One by one, they spoke, to a hushed audience. The facts were shocking. Each told of his or her age and made

Mrs. Hewit is a Director of the Woman's Auxiliary to the Woman's Auxiliary to the American Medical Association and serves as chairman of the Health Education Committee, having served as President of the Woman's Auxiliary to the Florida Medical Association in 1968-1969.

a plea for help. The youngest was thirteen years old.

As one young man spoke, in a somewhat muffled voice, a member of the audience said, "Why do you not show your face? If you want our help let us see you."

"I cannot," the young voice replied. "My mother and father are in the audience."

A silent hush fell over the auditorium, with parents looking at each other, helplessly. Their thoughts were easy to read.

"Could that be our son?" was the question everyone faced. "Could we have been so blind?"

For, there, in their own beautiful and prosperous county, dominated by Phoenix and Scottsdale, with a large upper middle class and affluent society, their children had fallen prey to the pushers who lurk around those places visited by the young and innocent. They think nothing of wrecking young lives and causing many lifetimes of anguish and even death. The tornado-like whirlwind of drug abuse was leaving devastating damage. Here, as across the nation, young persons had lost their lives, suffered irreparable damage or were facing years of rehabilitation. Many were serving prison terms, as most resort to crime to support their habit. Many will not recover enough to realize their former potential in life.

The committee, in Maricopa County, decided to take immediate action, but they knew they could not do this alone. To be successful they must have total community involvement. Before they could invite the community to take part, the doctors knew they must become better educated about drug abuse themselves. This would require study, leadership and hours of work, and, this is what they did. They met and educated themselves, becoming more knowledgeable about the problem, how to treat their victims and how to fight back. The next step was to invite community leaders to participate, and to educate them. The medical auxiliary was called into action and was asked to make phone calls and to interest people in the program.

The result was the formation of the Community Organization for Drug Abuse Control, now known as CODAC. Thus, Maricopa County, Arizona became "the first community in the nation to respond to the distress and the anguish, and organized to contain and control the problem of indiscriminate misuse of dangerous drugs."

"I find it extremely exhilarating to see the way Phoenix has led other cities in its attack on the drug problem. It has become the model for other American cities to follow," said John N. Mitchell, former United States Attorney General.

How does CODAC function, and who does it benefit? CODAC benefits the entire community. Every young person, who is convinced not to experiment with drugs, is benefited. Every drug-user, who is rehabilitated back to a useful life, is a community benefit. As people get off drugs, the crime rate is markedly decreased. CODAC has grown, in three years, to include many agencies and has become a vital force in Phoenix. Service clubs, hospitals, schools and churches joined in the movement. Such a drug abuse program is available to everyone needing help, regardless of race, creed, religion or ability to pay. CODAC has four facilities to serve the community. On a tour of these units we visited the following:

Terros, Inc., a contact and referral center providing emergency services, counseling and free clinics. Here young people come in from the street, seeking help, or are carried in, in an unconscious state. The facility mans two ambulance-type vehicles, both donated by citizens. They are furnished with the latest of life-saving equipment.

The staff includes both professionals and volunteers and is open 24 hours a day. The first service unit to be opened by CODAC, it took care of 2,629 clients in 1971. Its 1972 budget is $166,547.

The Valle Del Sol Narcotics Prevention Project is located in the Spanish-American area of the city. It offers counseling, vocational therapy and a methadone maintenance program, aimed at reaching and rehabilitating the inner city addict. The staff consists of a director, administrator, secretary, nurses, counselors, narcotic specialists and assistants. Its budget for 1972 is $164,543, and it is partially funded by the National Institute of Mental Health.

The Arizona Family Facility, housed in a former hospital, tucked into the side of a mountain, is for longterm residents. Its 1972 budget is $153,173 and is designed for the rehabilitation of hardcore addicts.

Here the young victims of the "now society" talk freely of their problems, how they committed crimes in order to obtain funds to support their habit, and of their weeks, months and years behind bars. They are referred to this facility by the courts and remain from four to six months.

We talked with several of these young men and women, and the tales of their experiences seemed almost beyond belief. Hopefully, with this kind of care, many will again become useful citizens.

The last stop on the CODAC tour was the Creative Living Foundation for outpatient therapy and a live-in residential center for younger patients. Many of its residents were working on arts and crafts and seemed happy in their cheerfully decorated temporary home. It has a budget of $114,793.

One of the most outstanding educational activities of CODAC is their Teen Involvement program. This corps is made up of 1,500 high school teen counselors. These students have been trained to carry the antidrug message to every 5th, 6th, 7th and 8th grader in the county. The younger child listens to these bright young people more rapidly than he will accept the advice and teachings of his parents and teachers. The budget for this program is $48,307.

A physician is president of the CODAC Volunteer Directors Executive Committee and many other physicians and their wives serve with him. Their interest has been unswerving, from the beginning, and the community has recognized their fine leadership. The entire county has been mobilized with a unanimity of purpose. Business people, law officers, pharmacists, the media, just about every civic group has cooperated in this magnanimous undertaking. "CODAC became the thing to be interested in, and everyone joined in the battle," one of the founders said.

An annual fundraising campaign is held with everyone joining in to make it go over the top. Annually it proves that a concerned community will give more than a half million dollars.

Every county medical society and auxiliary should take a second look at the "drug scene" in its community. Many words have been written about the problem and many doors have been opened. Some communities have a Hot-Line type of communication, some have established Halfway Houses and others a clinic type of facility. Many have educational projects in the schools and all of these things are good. But, in many communities the door to help remains closed. It may be due to apathy, lack of community cooperation or lack of funds. Whatever the reason, there is still time for every community to reach out and open the door and the doctors and their wives can do it! We realize that every place cannot go so far as to duplicate CODAC, but, just as in Maricopa County, medical groups have and are joining forces and mobilizing the community to lick the drug problem. Through Education, Prevention, Contact and Referral Services and Treatment and Rehabilitation this menace can be wiped out of the place where you live.

What does your county need? Is the problem being met? Isn't NOW the time to really face up to the problem of drug abuse, and do something about it? Wouldn't it be a fine public service program for your county society? We grant it will take hours of volunteer service, and to be successful, you should involve the entire community. The young lives you save from the drug abuse menace will be reward enough for your efforts!

Note: Further information may be obtained by writing CODAC, 719 North Street, Phoenix, Arizona 85004.

▶ Mrs. Hewit, 3305 Mullen Avenue, Tampa 33609.

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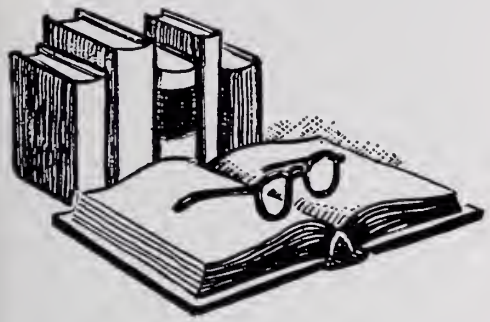
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Book Reviews

Handbook of Clinical Dermatoglyphs by Musallam S. Elbualy and Joan D. Schindeler. Pp. 64. Price $6.95. Coral Gables, University of Miami Press, 1971.

The authors intend this book for physicians who are not expert in the field of dermatoglyphs. The subject has been simplified and the illustrations have been freely utilized, along with annotations rather than long descriptions, so that the physician will be able to easily compare his patient's findings with those in the book.

Illustrated are the dermatoglyphs of Down's Syndrome (Mongolism), Trisomy D, Trisomy E, Cat Cry Syndrome, Turner's Syndrome, Klinefelter's Syndrome, DeLange Syndrome, and other syndromes.

The text is clear, quite concise, and easy to read. It is recommended for those who are inexperienced in this discipline.

Perry A. Sperber, M.D.
Daytona Beach

Stereocolposcopic Atlas of the Uterine Cervix by Joseph W. Scott, M.D. Pp. 117. Illustrated. Price $37.50. Published by Zephyr Publishers, Kendall, Florida in two volumes, 1971.

Dr. Scott, a recognized authority and accomplished culposcopist, has compiled a series of 42 stereophotographs of the cervix collected over an 8 year period in a new 2 volume atlas. One volume contains 42 pairs of stereophotographs and a small collapsible viewer, while the second volume contains accompanying black and white photographs with a detailed explanation of each picture. The photographs are extremely detailed and of fine quality, and present a way of viewing the cervix most American gynecologists have not seen before. The stereophotographs permit a three dimensional view as would normally be seen during examination, rather than the traditional two dimensional view shown in most photographs.

Culposcopy has gained wide acceptance in Europe and South America, but is not routinely used in the United States. The culposcope is actually a low power microscope with a built in light source that enables the gynecologist to view the cervix in much greater detail than has been done before. The author points out that abnormal areas of the cervix can be readily seen and biopsies, if indicated, can be taken with greater precision than when the cervix is viewed with the naked eye. This, he points out, eliminates the need for unnecessary and expensive conizations and hospitalizations, and allows for earlier and more accurate diagnoses.

Dr. Scott has chosen 42 representative illustrations out of 6,000 photographs he has taken in the course of some 15,000 culposcopies. It is a beautifully illustrated atlas, accompanied by a brief and practical text that is a useful guide for the beginning culposcopist. The atlas also contains a glossary which this reviewer found superfluous, defining terms that should be familiar to every gynecologist.

With the possible exception of an occasional slide appearing out of focus to this reviewer's eyes, and a failure to identify an occasional area of one photo, this atlas is an otherwise valuable addition to the gynecologist's library and a jumping-off point for the novice culposcopist.

Steven M. Weissberg, M.D.
Miami

Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

Cardiovascular Physiology, Second Edition, by Robert M. Berne, M.D. and Matthew N. Levy, M.D. Pp 265. 193 Illustrations. Price $9.25. St. Louis, The C. V. Mosby Company, 1972.

Synopsis of Gynecology, Eighth Edition by Daniel W. Beacham, M.D. and Woodward D. Beacham, M.D. Pp. 413. 209 Illustrations. Price $10.90. St. Louis, The C. V. Mosby Company, 1972.

The Truth About Vitamin E by Martin Ebon. Pp. 154. Price $1.25. New York, Bantam Books, Inc., 1972.

Hematopoietic and Gastrointestinal Investigations with Radionuclides by Albert J. Gilson, M.D., William M. Smoak III, M.D. and Morton B. Weinstein, M.D. Pp. 456. Illustrated. Price $30. Springfield, Ill., Charles C. Thomas, Publisher, 1972.

Cancer Diagnosis in Children by L. D. Samuels, M.D. Pp. 131. Illustrated. Price $25. Cleveland, Ohio, CRC Press, 1972.

The Chinese Art of Healing by Stephan Palos. Pp. 237. 50 Illustrations. Price $1.50. New York, Bantam Books, Inc., 1972.

The Care of Minor Hand Injuries by Adrian E. Flatt, M.D. Pp. 293. 323 Illustrations. Price $21.50. St. Louis, The C. V. Mosby Company, 1972.

A Civilian Doctor in Vietnam by Fred Gloeckner, M.D. Pp. 123. 27 Illustrations. Price $5. Philadelphia, Pa., The Winchell Company, 1972.

Introduction to Neuroscience, Edited by Jeff Minckler, M.D., Ph.D. Pp. 420. 661 Illustrations. Price $22.50. St. Louis, The C. V. Mosby Company, 1972.

Review of Medical Microbiology by Ernest Jawetz, M.D., Ph.D.; Joseph L. Melnick, Ph.D.; Edward A. Adelberg, Ph.D. Pp. 518. Illustrated. Price $8.00. Los Altos, Calif., Lange Medical Publications, 1972.

General Urology by Donald R. Smith, M.D. Pp. 436. Illustrated. Price $8.50. Los Altos, Calif., Lange Medical Publications, 1972.

Mental Health Training and Public Health Manpower by Stephen E. Goldston, Ed. D., M.S.P.H. and Elena Padilla, Ph.D. Pp. 294. Price $2.75. Rockville, Maryland, National Institute of Mental Health, 1971.

Review of Medical Pharmacology, Third Edition by Frederick H. Meyers, M.D., Ernest Jawets, M.D. and Alan Goldfien, M.D. Illustrated by Laurel V. Schaubert. Pp. 688. Price $8.50. Los Altos, Calif., Lange Medical Publications, 1972.

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Indications: Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (*i.e.*, several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.

Contraindications: Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.

Warnings: When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.

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Usage In Pregnancy: The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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OCTOBER COVER—Our hard working Board of Governors. See page 52.

President's Page



National Health Service Corps

I wonder how many of us in Florida are aware of the National Health Service Corps Program. This is a program which has been set up by our federal government to provide medical, dental and other health manpower to communities which have been designated as shortage areas. This Corps is made up largely of young men finishing their training, who have an obligation to serve in some branch of federal service before entering their own private practice. Presently, local and state professional societies, as well as local government, must certify the need for NHSC personnel. The Corps, after some six months of operation, now serves approximately 143 communities throughout the nation. One of the key objectives of this program has been to encourage NHSC members to remain in the community after their term of required service has been completed. So far, the program seems to be working fairly well, and we have five areas in our state which are currently using physicians and/or dentists under this program.

I feel that one of the most important provisions of this program is the necessity of having local medical societies and state medical associations certify the need for such a doctor in their own community. This provision was strongly pushed by organized medicine, and I believe our own U.S. Congressman, Paul Rogers, was instrumental in seeing that it was included in the original bill.

Now, less than a year after passage, Senator Kennedy has introduced Senate Bill 3858, which is the Emergency Health Personnel Act Amendment of 1972. This bill would extend and modify the National Health Service Corps Program, but one of the provisions would be to remove the necessity for local certification of need. The new amendment would leave this determination up to the Secretary of HEW, with merely the privilege of consulting with local medical societies.

Here again is a federal program which apparently has started well but before a year old, an attempt is being made to modify it and take it out of the hands of local physicians. At the time of writing this page, the AMA is testifying before the Senate Health Subcommittee in an effort to either defeat this amendment or retain the provision of county and state determination of need. Merlin K. Duval, M.D., Assistant Secretary for Health and Scientific Affairs, is testifying for the Administration, and has urged that no action be taken at this time on changing the bill. The Student American Medical Association has also recommended retention of the provision requiring certification by local government.

I don't know how this bill will come out, but I felt that it was interesting to point out to our members that your national organization, the AMA, continues to fight daily in Washington in an attempt to hold off bureaucratic encroachment into our local community practice of medicine. I urge you to stay abreast of these rapidly changing affairs and contact your Senators and Congressmen regarding our wishes and feelings.

William J. Dean, M.D.

Arthur lost



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Highly effective. Active against pinworm...and roundworm.

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Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 μg/ml) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia.

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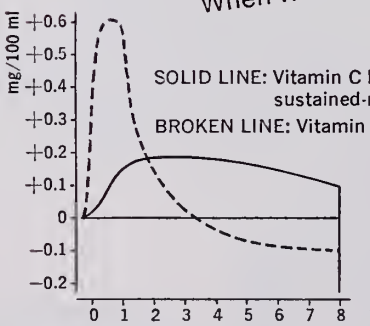


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*Comparison of ascorbic acid blood levels after administration of 1 gram of ascorbic acid in effervescent tablet form and 1 gram of CEVI-BID (2 capsules). *Adaptation

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1. Riccitelli, M. L.: Vitamin C Therapy in Geriatric Practice, J. Amer. Geriatrics Soc. 20: 34, 1972.

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Dean's Page

The First Year of Academic Operation at the University of South Florida College of Medicine

Donn L. Smith, M.D.

At the end of the first academic year at the College of Medicine, it seems worthwhile to recapitulate the activities and some of the more significant events of the year. The first and most important happening occurred on September 8, 1971, when the charter class of 24 arrived to begin the first year of their undergraduate work. The curriculum and a myriad of administrative arrangements had been achieved so that the entire year and all of its activities had been programmed in advance. As a result, from the academic point of view the operation has moved ahead as scheduled. All members of the class have, predictably, done well and there was no attrition resulting from academic failure or other reasons.

Accreditation as a developing School of Medicine was extended without incident. The second class to enter has been selected from over 600 in-state applicants and began their studies in July, 1972. A three-year curriculum has been designed and approved by the faculty for implementation in July, 1972. This curriculum, which is now in effect, will contain approximately the same number of contact hours as were in the original four-year curriculum.

A major milestone was reached upon federal approval and funding for the ten million dollar Phase I construction program which will provide a more modern and functional home for the College. This facility is now under construction and will be completed by January 1974. The legislature has generously provided adequate funding for operational costs and this has made some acceleration possible in the overall staffing program. Recruitment of faculty and staff is on schedule with an excellent, highly qualified faculty on the scene and additional faculty arriving almost daily. The departmental chairmen for the major departments that have been recruited are listed below with the Universities from which they received their degree:

Anatomy—James Ward, Ph.D., University of Mississippi
Internal Medicine—Roy Behnke, M.D., Indiana University
Medical Microbiology—Charles Fishel, Ph.D., University of Chicago
Obstetrics/Gynecology—James Ingram, M.D., Duke University
Ophthalmology—William Edwards, M.D., Yale University
Pathology—Herschel Sidransky, M.D., Tulane University
Pediatrics—Lewis Barness, M.D., University of Pennsylvania
Pharmacology—Andor Szentivanyi, M.D., University Medical School of Debrecen (Hungary)
Physiology—Carleton Baker, Ph.D., Princeton University
Psychiatry—Walter Afield, M.D., Johns Hopkins University
Surgery—Roger Sherman, M.D., University of Cincinnati

The administrative staff includes the Dean: Donn L. Smith, Ph.D., M.D., University of Colorado; Associate Deans: Jack Hickman, M.D., Indiana University; Charles Fishel, Ph.D., University of Chicago; and Assistant Dean for Admissions: Julian Dwornik, Ph.D., University of Manitoba; Curriculum: Rudolf Noer, M.D., University of Pennsylvania; Vivarium: Louis Nelson, D.V.M., Auburn University; Medical Librarian: Fred Bryant, M.S., Emory University; and Business Manager: John Melendi, B.A., Florida Southern College.

With competent faculty, able students and excellent, modern physical facilities assured, the future of the College of Medicine is one of viability and substantial potential. The support and help of a goodly number of the Tampa Bay area private medical practitioners is acknowledged with gratitude. Exciting and meaningful assistance has been rendered both in instruction and administration by members of the medical community. On behalf of the faculty, students and the University, I wish to extend sincere thanks to all concerned.

It has been a productive and stimulating year. It represents the first visible step towards the achievement of our long term objective which is to create and maintain a distinguished College of Medicine.

Dr. Smith, University of South Florida, Tampa 33620.

Dr. Smith is Director of the Medical Center and Dean of the College of Medicine, University of South Florida, Tampa.

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If not, the new Rocom Health History Questionnaire asks questions in Spanish...

1	¿Le molestan coyunturas o músculos rígidos o dolorosos?	I. Sí X No ___	13. MUSCULOSKELETAL
2.	¿Se le hinchan las coyunturas?	2. Sí ___ No X	X aching muscles or joints
3.	¿Le molestan dolores en la espalda u hombros?	3. Sí X No ___	___ swollen joints
4.	¿Le duelen los pies con frecuencia?	4 Sí ___ No X	X back or shoulder pains
5.	¿Esta desabilitado en alguna manera?	5. Sí ___ No X	___ painful feet
			___ handicapped
6.	¿Tiene algun problema con su piel?	6. Sí ___ No X	14. SKIN
7.	¿Le pica o quema la piel?	7. Sí ___ No X	___ skin problems
8.	¿Sangra por largo tiempo cuando se hace una pequeña cortadura?	8. Sí ___ No X	___ itching or burning skin
9.	¿Se lastima facilmente formando un cardenal o morete	9 Sí ___ No X	___ bleeds easily
			___ bruises easily
10.	¿Se ha desmayado o se ha sentido como que se va a desmayar?	10. Sí ___ No X	15. NEUROLOGICAL
11.	¿Tiene alguna parte del cuerpo siempre adormecida?	11. Sí X No ___	___ faintness
12	¿Ha tenido alguna vez convulciones?	12. Sí ___ No X	X numbness
13.	¿Le ha cambiado ultimamente su letra al escribir?	13. Sí ___ No X	___ convulsions
14.	¿Tiene tendencia a temblar o menearse mucho?	14. Sí ___ No X	___ change in handwriting
			___ trembles
15.	¿Se pone nervioso en presencia de personas extranas?	15 Sí X No ___	16. MOOD
16.	¿Se le hace difícil tomar decisiones?	16. Sí X No ___	X nervous with strangers
17	¿Se le hace difícil concentrar o recordar?	17. Sí X No ___	X difficulty making decisions
18.	¿Se siente solo o deprimido?	18 Sí ___ No X	X lack of concentration or memory
19.	¿Llora a menudo?	19. Sí ___ No X	___ lonely or depressed
20.	¿Diria usted que tiene una perspectiva irremediable?	20. Sí ___ No X	___ cries often
21.	¿Tiene dificultad en relajar o reposar?	21 Sí X No ___	___ hopeless outlook
22.	¿Tiende a preocuparse demasiado?	22 Sí X No ___	X difficulty relaxing
23.	¿Le molestan o asustan algunos sueños o pensamientos?	23 Sí ___ No X	X worries a lot
24.	¿Tiende a ser timido o sensitivo?	24 Sí ___ No X	___ frightening dreams or thoughts
25	¿Se molesta mucho cuando lo critican?	25 Sí X No ___	___ shy or sensitive
26.	¿Pierde el genio con frecuencia?	26 Sí X No ___	X dislikes criticism
27.	¿Cosas pequeñas lo hacen molestar?	27 Sí X No ___	X loses temper
28	¿Le molesta cualquier trabajo o problemas familiares?	28. Sí ___ No X	X annoyed by little things
29	¿Tiene algún problema con su vida sexual?	29 Sí ___ No X	___ work or family problems
30.	¿Ha considerado alguna vez suicidarse?	30. Sí ___ No X	___ sexual difficulties
31	¿Ha deseado alguna vez, o buscado, ayuda psiquiatrica?	31. Sí X No ___	___ considered suicide
			X desired psychiatric help

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provides answers in English

When your patient speaks little English and your Spanish is limited or nonexistent, you need the new ROCOM Health History Questionnaire (Spanish).*

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Indications: Stable adult diabetes mellitus; sulfonylurea failures, primary and secondary; adjunct to insulin therapy of unstable diabetes mellitus.
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Warnings: Use during pregnancy is to be avoided.
Precautions: 1. *Starvation Ketosis:* This must be differentiated from "insulin lack" ketosis and is characterized by ketonuria which, in spite of relatively normal blood and urine sugar, may result from excessive phenformin therapy, excessive insulin reduction, or insufficient carbohydrate intake. Adjust insulin dosage, lower phenformin dosage, or supply carbohydrates to alleviate this state. **Do not give insulin without first checking blood and urine sugar.**
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...in the presence of spasm or hypermotility, gas distention and discomfort, **KINESED®** provides more complete relief:

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Precautions: Administer with caution to patients with incipient glaucoma, bladder neck obstruction or urinary bladder atony. Prolonged use of barbiturates may be habit-forming.

Side effects: Blurred vision, dry mouth, dysuria, and other atropine-like side effects may occur at high doses, but are only rarely noted at recommended dosages.

Dosage: *Adults:* One or two tablets three or four times daily. Dosage can be adjusted depending on diagnosis and severity of symptoms.

Children 2 to 12 years: One-half or one tablet three or four times daily. Tablets may be chewed or swallowed with liquids.

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to move,
and the Latin **sedatus**,
to calm)

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This southwestern desert lizard seeks
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When attempts are made to probe him
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until his torso is distended up to
sixty per cent over its normal size...
thus wedging himself tightly
in place and preventing capture.

FEEDBACK - from Pearl Street

Coccidioidomycosis

Two cases of coccidioidomycosis have just been reported, a 59-year old woman living in Osceola County and a thoracic surgeon from Orange County. The diagnosis in both cases was made from mycologic culture of bronchial washings. Epidemiologic investigation indicates that both cases were acquired in California, a known endemic focus for coccidioidomycosis. *Coccidioides immitis,* the agent responsible for this disease, has been reported only in the arid and semiarid regions of the southwestern United States, Mexico, Central America, Venezuela and in the Chaco region of Argentina. The disease is rarely, if ever, transmitted person-to-person; inhalation of dust containing the spores of this organism is the usual mode of acquisition. No one has yet documented the in-Florida transmission of this disease.

Typhoid Follow-up

The case of typhoid fever in a 10-year old girl from Alachua County reported last month has apparently been traced to the child's mother, a probable typhoid carrier. All other potential sources of infection for the girl have proved negative. This woman cannot recall ever having had typhoid fever, although her stools are positive for *S. typhosa.* Such a situation is uncommon, but certainly not unprecedented.

Measles and Other Rashes

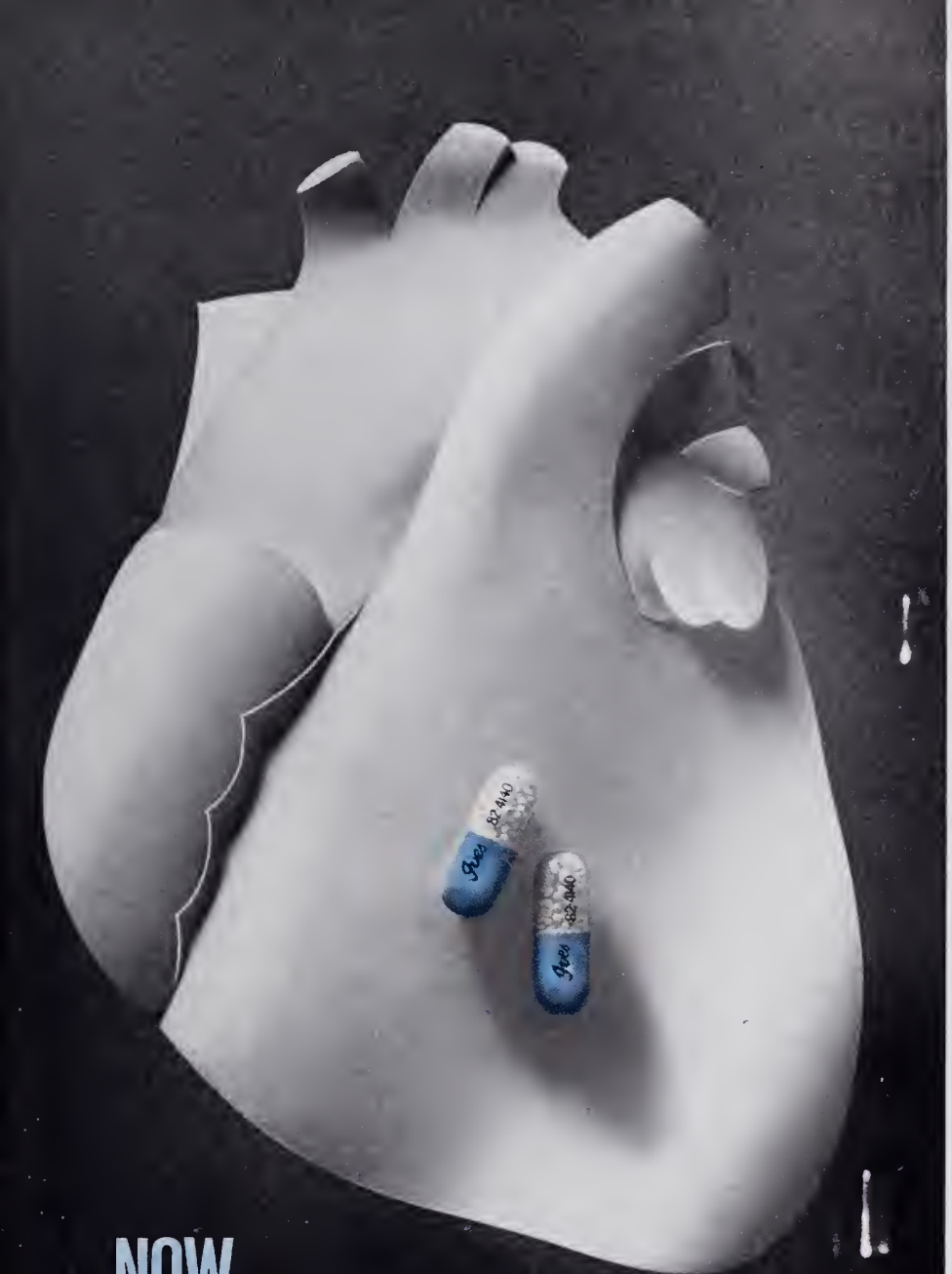
Reported cases of measles are few and far between in recent weeks, and we are currently running about 25% fewer cases in the State as a whole than we did at this same time last year. Some 10 to 15 sets of paired sera a week from patients with a morbilliform eruption are now being processed by the State Bureau of Laboratories. Only one case has proved to be rubeola. When a frozen stool specimen accompanies the sera, culture for enterovirus becomes feasible. Many of the cases negative for rubeola serologically have yielded ECHO or Coxsackie virus on stool culture. Unfortunately, the serologic tests that have proved so valuable in the diagnosis of measles, rubella, and other diseases are not yet available for the enteroviruses, and it is this latter group that is responsible for much of our summer and early fall exanthemata. There is some evidence that reporting of measles cases is not as complete as it ought to be and the following illustration will serve to make this point: as many cases of measles have been reported from Polk County (40) this year as from Broward, Dade, Monroe and Palm Beach Counties combined, with a population ten times that of Polk's.

Influenza—A Prediction

Although predictions in biological systems are always subject to uncertainty (and the medical equivalent of the Monday morning quarterback should be relishing this opportunity), it seems likely that Floridians can expect some localized outbreaks of A2-Hong Kong influenza as well as Influenza B illness during the 1972 season. Because of the widespread illness of this past winter, it seems unlikely that we are in for a significant problem during this coming season.

Influenza Vaccine, General Recommendations

Annual vaccination is recommended for chronically ill persons of all ages with cardiovascular, pulmonary, renal or metabolic disease. This group includes patients living in nursing homes and other institutions where arrangements may facilitate the spread of the disease once it is introduced. Ideally, vaccination should be scheduled for completion by mid-November. Since the primary series consists of two doses administered subcutaneously, preferably six to eight weeks apart, the time to start is now. Persons who have had one or more doses of vaccine containing the Hong Kong strain antigen (all influenza vaccines since 1968-1969) need only a single subcutaneous booster dose of the current bivalent vaccine. All others should receive the full primary series. Persons clearly hypersensitive to egg protein should not be given influenza vaccine. The current vaccine is different from that available in previous years. Although the type A strain present in 1971-72 is retained, its potency has been increased, and a more current type B strain replaces that of previous formulations.



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One capsule b.i.d. helps protect your angina pectoris* patients for up to 24 hours a day.

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Widely accepted Isordil Tembids Tablets are r joined by an additional sustained action form, Isordil Tembids Capsules, providing greater p scribing flexibility.

***Indications:** Based on a review of this drug b the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indication as follows:

"Possibly" effective: When taken by the oral route, Isordil (isosorbide dinitrate) is indicate for the relief of angina pectoris (pain of cor- onary artery disease). It is not intended to ab the acute anginal episode, but is widely re- garded as useful in the prophylactic treatmen of angina pectoris.

Final classification of the less-than-effective dications requires further investigation.

Contraindication: Idiosyncrasy to this drug.

Warnings: Data supporting the use of nitrites ing the early days of the acute phase of myoc dial infarction (the period during which clinic and laboratory findings are unstable) are insu cient to establish safety.

Precautions: Tolerance to this drug and cross tolerance to other nitrites and nitrates may o In patients with functional or organic gastroir testinal hypermotility or malabsorption syndro it is suggested that either the ISORDIL 5 mg. 10 mg. Oral tablets or sublingual tablets be th preferred therapy. The reason for this is that patients have reported passing partially disso ISORDIL TEMBIDS tablets in their stools. This phenomenon is believed to be on the basis of physiological variability and to reflect rapid g trointestinal transit of the sustained action ta TEMBIDS SHOULD NOT BE CHEWED.

Adverse Reactions: Cutaneous vasodilation wi flushing. Headache is common and may be se and persistent. Transient episodes of dizzines and weakness as well as other signs of cerebr ischemia associated with postural hypotensio may occasionally develop. This drug can act a physiological antagonist to norepinephrine, ac tylcholine, histamine, and many other agents. occasional individual exhibits marked sensitiv to the hypotensive effects of nitrite, and seve responses (nausea, vomiting, weakness, restle ness, pallor, perspiration and collapse) can oc even with the usual therapeutic dose. Alcohol enhance this effect. Drug rash and/or exfoliat dermatitis may occasionally occur.

Consult direction circular before prescribing.

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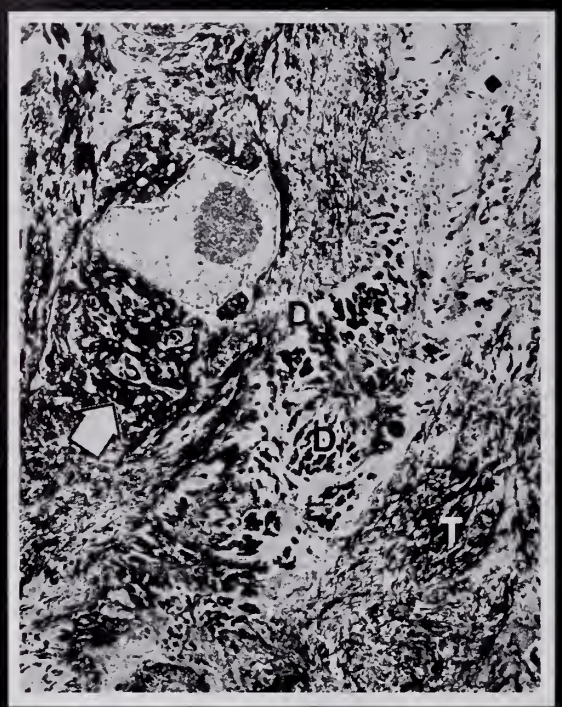
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Lesion #2—Two days after initiation of therapy. Electron micrograph of solar keratotic skin from patient's hand.
Typical abnormalities are:
Malpighian cells [containing an abundance of thick tonofibrils (T)] which are connected with well-developed desmosomes (D). Note the clumped tonofibrils in the so-called 'dyskeratotic' cell (arrow) indicative of solar keratosis. No change can be noted at this level after two days of therapy. × 5000 (12/16/71)



Lesion #3—Two weeks after initiation of therapy. Electron micrograph of skin from patient's hand.
Improvement shown:
Less conspicuous desmosomes (D), widened intercellular spaces and Malpighian cells showing a remarkable reduction of tonofibrils (T). The arrow indicates a degenerating dyskeratotic cell. × 5000 (12/31/71)

Solar, actinic or senile keratoses

By whatever name they may be known, they commonly occur as multiple lesions and chiefly on the exposed portions of the skin. Because they may be premalignant, it is generally agreed that they should be treated. Surgery, cryotherapy, or electrodesiccation may present certain drawbacks, both for the physician and the patient, but there is Efudex® (fluorouracil)—as an alternative to conventional therapy.

Sequence of therapy—Selectivity of response

The easily applied Efudex cream or solution usually begins to show effects within a few days—an erythema in the area of the lesions. Within two weeks after initiation of therapy, this reaction usually reaches its height of unsightliness and discomfort, declining after discontinuation of therapy. This reaction occurs in affected areas. Since the response is so predictable, lesions that do not respond should be biopsied to rule out the presence of a frank neoplasm.

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Treatment with Efudex (fluorouracil) provides highly acceptable cosmetic results posttherapeutically. The incidence of scarring is low.* This is particularly important with multiple facial lesions. Efudex should be applied with care near the nose, eyes and mouth.

5% cream/solution—a Roche exclusive

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*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.

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JFMA
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OCTOBER, 1972 • VOLUME 59 • NUMBER 10

Temporal Profile
Differential Diagnosis of Stroke Syndrome

JACOB GREEN, M.D.

Abstract: This paper is a reassessment of the clinical and bedside approach to diagnosis of the "stroke syndrome." By utilization of the criteria outlined, an early diagnosis and in most cases, appropriate preventative and remediable therapy of stroke can be accomplished. A review of 222 cases of "stroke" and explanation into the rationale of carotid artery surgery is undertaken. Review of the literature on carotid artery operation is also presented.

Stroke is defined as "a blow; a sudden attack."[1] It is proposed that one can readily separate the treatable causes of the stroke syndrome by analysis of the speed and manner in which "the blow falls." Where correct etiologic diagnosis can be established and proper therapy instituted before irreversible damage has taken place, a number of patients may be salvaged from severe disability and/or death.

The importance of temporal profile in the development of "stroke" can be found in numerous standard texts concerned with principles and practice of medicine.

"The stroke syndrome is the common denominator of all cerebral vascular disease, and is chiefly recognized by its temporal profile, and characteristic focal neurologic deficit. The suddenness of its onset stamps it as 'vascular' as the brain depends upon the moment to moment supply of oxygenated blood."[2]

"Cerebrovascular accidents are classified on the basis of anatomic site of ischemia or infarction, the cerebral vessels occluded, or obstructed and the temporal character of the entire clinical episode. The latter (temporal character) is clinically the most valuable in that the indicated therapy is often different for the three kinds of temporal profile found (transient ischemic attacks, stroke in progression, and completed stroke.)"[3]

It is suggested that in this day of increasing emphasis on specialized procedure such as angiography and electroencephalography, a great deal of insight into the particular stroke syndrome can be accomplished by the time-tested clinical evaluation, i.e., a good history and bedside examination.

One can, in many instances, rapidly strike back at stroke, the third major cause of death in the United States.

The most important remediable cause of this syndrome is extracranial vascular disease. Historically, Hunt first called attention to the importance of extracranial vascular disease in 1914.[4] Moniz opened the field of investigation of the entire cerebral circulation with development of angiography in 1927.[5] Fisher pointed out the great importance of extracranial vascular diagnosis to cerebral insufficiency in 1951.[6,7] In 1954 the first operation for this entity was carried out by Carrea, Molins and Murphy.[8] Hutchinson

and Yates[9] in 1957 pointed to the complex interrelationship of vertebral and carotid circulatory disease. Since then many classic studies have appeared regarding the stroke syndrome, extracranial vascular disease and its correction.[10,11]

Two hundred twenty-two consecutive cases of "stroke syndrome" were studied. The initial diagnoses, based on the clinical criteria to be outlined, were then tabulated. The "final diagnosis" was based upon a review of all studies performed, arteriography, electroencephalography, lumbar puncture, x-ray and autopsy, and the results compared.

Criteria of Diagnosis

All vascular disease follows the same general time sequence. Each, however, has its own distinctive pattern and characteristics (Chart I).

I. Cerebral Thrombosis may be divided into three distinct categories.[12,13]

1. Transient Ischemic Attacks: These are attacks of neurological deficit lasting 30 minutes to several hours. They may be repetitive or culminate in the formation of "stroke in evolution" and/or "completed stroke." The usual category suggests that these individual episodes may precede, in finality, the "completed stroke syndrome."

2. Stroke in Evolution: This entity suggests a neurological deficit which waxes and wanes over a period of time from up to 30 minutes to several hours or days, usually culminating in a "completed stroke."

3. Completed Stroke: This entity is oftimes preceded by transient attacks of neurologic deficit previously mentioned, or "stroke in evolution." The temporal profile of this entity follows (Chart II).

II. Cerebral Embolus: The quickest of onset of all "strokes" is usually likely to occur in a matter of seconds until the time of maximum neurological deficit is reached. A stable period may be brief, followed by a complete recovery if the embolus is small and colateral circulation is adequate.

III. Intracerebral Hemorrhage: The time of onset of this particular entity is intermediate between the cerebral embolus and the cerebral thrombosis. This typically presents itself as a sudden headache followed by coma, hemiplegia, and is usually resultant in severe neurologic deficit or death (Chart III).[13]

IV. Subarachnoid Hemorrhage: This entity is most commonly due to ruptured "Berry" aneurysm. The time of onset to maximal headache is usually the same as the time of onset to maximal neurologic deficit and is usually measured in terms of minutes. This varies as to severity of the hemorrhage. Another cause includes arteriovenous malformation. Aneurysms alone, however, account for 5% of all "cerebral vascular accidents" (Chart IV).[13]

V. Subdural Hematoma usually progresses over a longer period of time with lethargy and increasing hemiparesis, often found in elderly and/or alcoholic patients.

VI. Cerebral Neoplasm: This entity is usually progressive in onset, accompanied by headache, papilledema, focal neurologic signs, seizures and other symptoms. However, the onset may be sudden and it may well mimic stroke syndrome.[13]

VII. Toxic and Metabolic Encephalopathy: This may be rather slow in onset and development. It is usually discernible from the clinical history and examination findings (nonfocal, diffuse involvement of central nervous system), laboratory data, BUN, blood sugar and blood ammonia.

Differential Diagnostic Procedures

Procedures used in the differential diagnosis of the stroke syndrome,[12] other than history and physical examination, are outlined. These were accomplished in many of the patients studied in this series.

I. Electroencephalography (EEG): This procedure consists of the external electrographic monitoring of cerebral activity by a recording device in which simultaneous samplings of various areas of adjacent cortical activity are recorded and compared.

II. Echoencephalography (Echo): A sonar-type beam is passed through the intact skull, returning its echoes from the midline structures (third ventricle), and analysis is made that might suggest expanding-mass lesion.

III. Ophthalmodynamometry: Compression of the orbital wall is accomplished with direct observation of the intraocular vasculature. Comparison of pressure recordings in each eye is made. A difference in blood pressures suggests a variation in internal carotid artery circulation; in that the ophthalmic artery is the first intracranial branch of this major vessel in its course.[14,15] The importance of the carotid vessels cannot be overemphasized; they may contribute 90% of total cerebral blood flow.[16]

IV. Brain Scan: In most cases this encom-

CHART I

TEMPORAL PROFILE OF "STROKE SYNDROME"

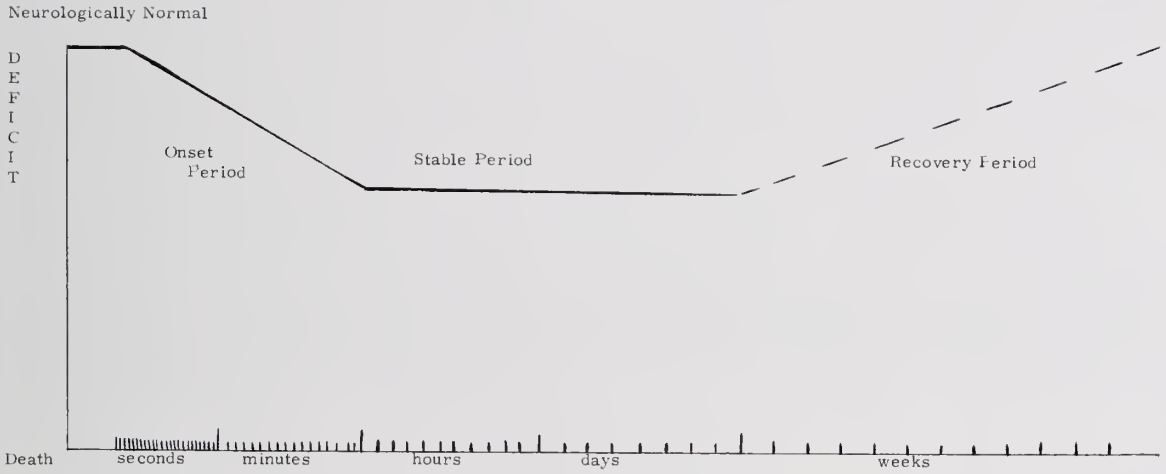
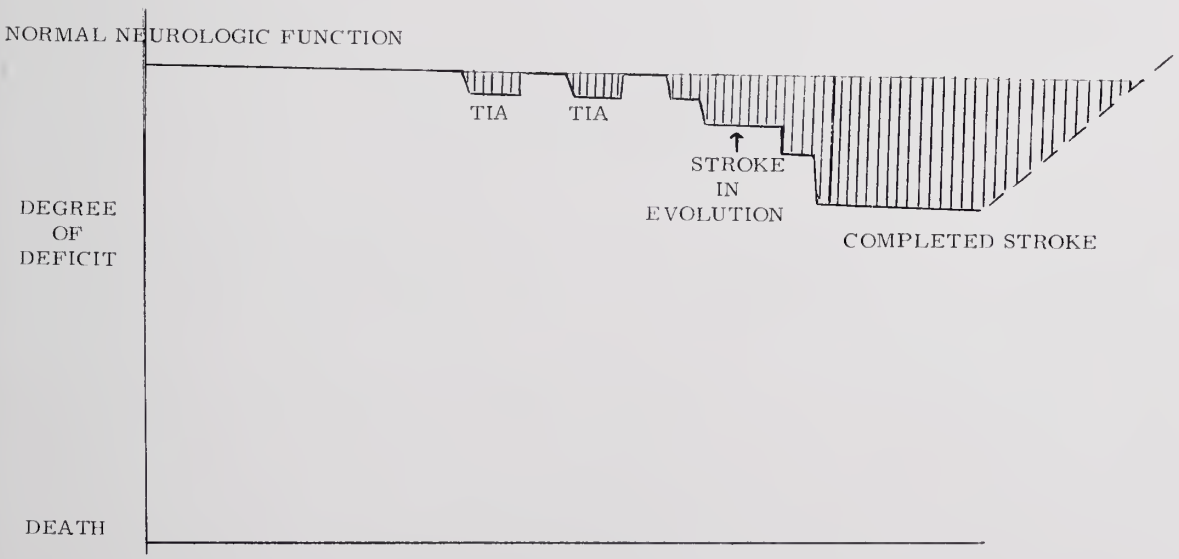


CHART II

TEMPORAL PROFILE OF CEREBRAL THROMBOSIS



TIA (Transient Ischemic Attacks): Multiple brief episodes of dysfunction
SIE (Stroke in Evolution): Progressive onset
Comp leted stroke: Prolonged stable period of moderate deficit

passes a dynamic phase in which technetium (Tc99) is administered intravenously and timed samplings of activity over each hemisphere are recorded in rapid fashion. This gives a rough assessment of cerebral circulation. Later a rectilinear scan is done in which areas of increased uptake, due to cerebral edema (tumor and infarction), may be identified.

V. Cerebral Angiography: Needles are inserted percutaneously into the carotid or brachiocephalic arteries under local anesthesia. Injection of contrast media through the cerebral circulation with seriographic x-ray recording is then accomplished. Extracranial obstruction, intracranial small vessel disease, subdural hematoma, neoplasm, aneurysm, and other treatable conditions can usually be *definitively* diagnosed by this procedure.

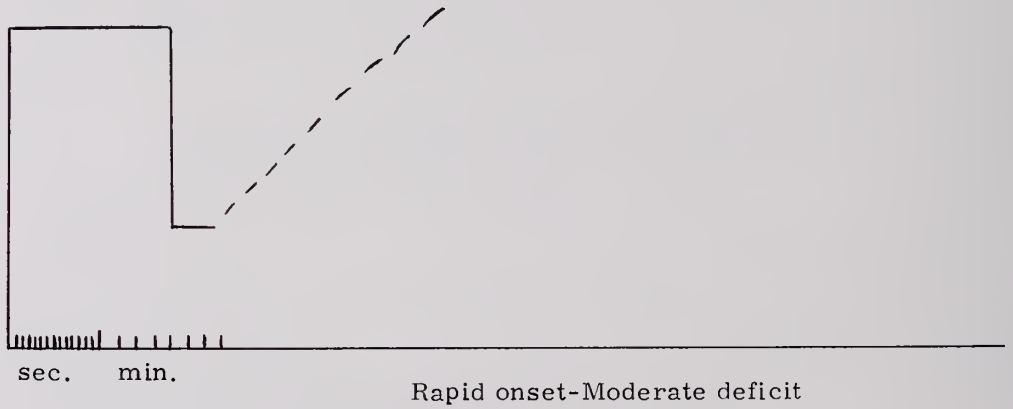
The 222 stroke patients had a total of 157 electroencephalograms, 48 echoencephalograms, 188 brain scans, 222 skull x-rays, 188 lumbar punctures, and 38 ophthalmodynamometric measurements. Arteriography was carried out in 130 of the total number of patients.

In six additional cases, the diagnosis was other than initially suspected by clinical criteria (Table 1). Bilateral subdural hematoma suspected in one case was revealed to be a toxic encephalopathy. Brain tumor suspected in three cases was proved by arteriography to be cerebral thrombosis of major proportion. Suspected aneurysm was found to be cerebral thrombosis in two cases. In every case of incorrect initial diagnosis, arteriography revealed the true nature of the lesion. The major cause of error was clearly inadequate historical information at time of initial evaluation.

It is suggested also that by further clinical follow-up of the patients that if the course is not

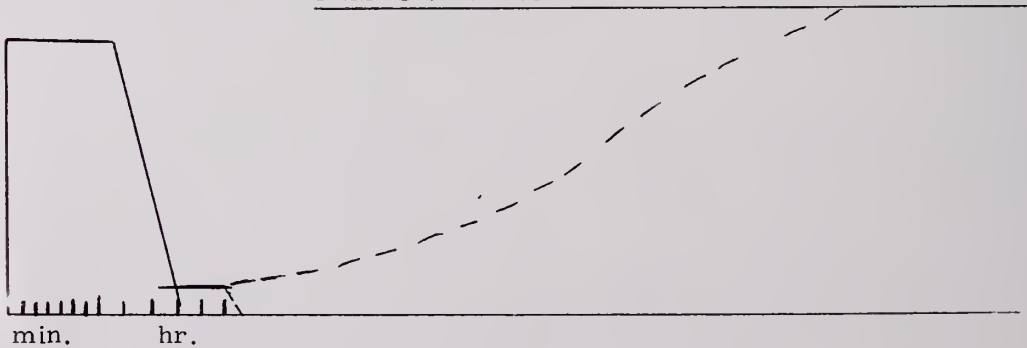
CHART III

TEMPORAL PROFILE OF CEREBRAL EMBOLUS



Rapid onset-Moderate deficit
Short stable period
Rapid Recovery

TEMPORAL PROFILE OF INTRACEREBRAL HEMORRHAGE



Profound deficit and death

as expected (the temporal profile), a complication or incorrect initial diagnosis can be immediately suspected.

Table 1.—Final Diagnosis Based on All Criteria.

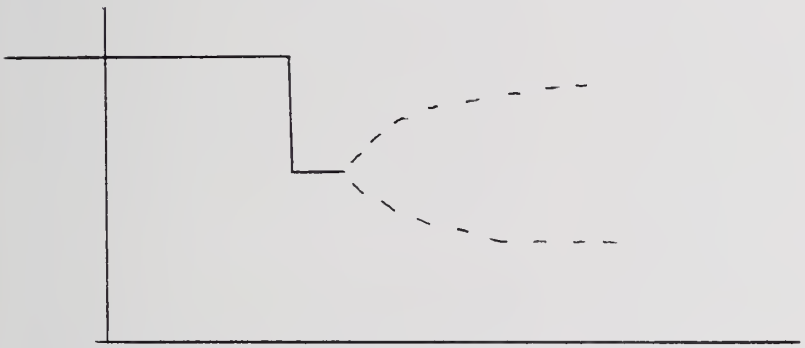
TYPE	NUMBER CASES	PERCENT CASES
Cerebral Thrombosis	179	81%
Cerebral Embolism	17	8%
Intracerebral Hematoma	7	3%
Subdural Hematoma	2	1%
Subarachnoid Hemorrhage	13	6%
Cerebral Neoplasm	3	1%
Toxic Encephalopathy	1	.5%
Errors in Diagnosis	6	3%

Discussion

In the analysis of the 222 stroke patient charts reviewed, it was revealed that 179 (81%) had cerebral thrombosis. Forty-nine (27%) of this group had, in fact, transient ischemic attacks prior to completed stroke. This correlates well with the figures presented by Gurdjian et al[17] in which 142 of 409 completed strokes had transient attacks—(34.5%). Thompson, however, suggests that as many as 75% may have transient ischemic attacks (228 of 300 cases) prior to "completed stroke."[18]

CHART IV

TEMPORAL PROFILE OF SUBARACHNOID HEMORRHAGE



Rapid onset - moderate severity

TEMPORAL PROFILE OF TUMOR



Progressive onset

In the case of transient ischemic attacks, arteriographically demonstrated extracranial abnormalities can ofttimes be subjected to surgical repair.[19-22] Data on this and other series[18,23] suggests that surgical removal of offending extracranial carotid (stenotic or ulcerative lesions) can often prevent the "completed stroke" in the patients suffering only transient ischemic attacks. Although it is suggested that stenosis of 63% is needed to retard cerebral blood flow,[24] other factors such as platelet emboli and cholesterol emboli must be considered.[25] Blood pressure is also of importance, in that hypotension can precipitate occlusion of a compromised vessel.

Occasionally, "stroke in evolution" appears to be similarly aided by surgical correction when due to incomplete obstruction of the internal carotid artery. Some authorities, however, do not agree with this statement[25] and feel that operation is of little value.

"Completed stroke" has, in the experience of this physician and others,[23] rarely been aided by the rapid restoration of cerebral circulation (as in completed extracranial internal carotid artery occlusion). The literature suggests damaging results in certain cases. Mortality rates for this operation (carotid endarterectomy) in "completed stroke" have been reported at 6.5% whereas in only "transient ischemic attacks" the mortality rate may be as low as 1%.[26]

Medical therapy (anticoagulation) of basilar artery ischemia can also ward off neurologic morbidity. Metabolic encephalopathy and multiple cerebral emboli can also be readily treated by medical means.

It is suggested by analysis of the "temporal profile" of the "stroke syndrome" that a correct etiologic diagnosis can be made. Appropriate diagnostic studies can be instituted and potentially correctable lesions such as "transient ischemic attacks" and "stroke in evolution" due to extracranial carotid artery can ofttimes be identified and remedied surgically. Subdural hematoma and intracerebral hemorrhage, along with subarachnoid hemorrhage, may also lend themselves to correction by surgical means. Early medical therapy can ward off basilar artery thrombosis, repeated emboli and toxic and metabolic encephalopathy.

Careful analysis of the temporal profile of the patients' difficulties correlated with the findings of neurological examination can enable the physician to render preventative service before "irreversible" damage occurs in many cases.

Accuracy of the "temporal profile" approach to the "stroke syndrome" suggests that 96% were correctly diagnosed on the basis of historical and examination findings, regardless of the other studies performed in this series.

Acknowledgment

The author would like to thank Dr. H. B. Curry of the Medical College of South Carolina for his interest in this subject and his teachings on this material.

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Smoking Habits of Florida Physicians Revisited

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Ashbel C. Williams, M.D., and William Braatz, M.P.H.

Abstract: This is a report of a 1972 survey of the smoking habits of 5,736 Florida physicians, a 66% response to the questionnaire. Comparison is made between this and the 1964 survey. Eighty-two percent of the physicians do not now smoke cigarettes as compared with 70% in 1964. Urologists and obstetrician-gynecologists smoke the most cigarettes while pathologists and radiologists the least. Fewer physicians start smoking, 25% had never smoked in 1964, 37% in 1972, and more continue to quit each year. It appears that the physicians of Florida are continuing their responsibility for public education about tobacco and health by personal example.

In 1964 the Florida Committee on Smoking and Health requested the Florida State Board of Health to plan and conduct a survey to determine the smoking habits of Florida physicians. Since the preparation and publication of the resulting study, Seventy Percent of Florida Physicians Are Nonsmokers,[1] events in smoking and health have led to Surgeon General Jesse L. Steinfeld, M.D., in his 1971 report,[2] labeling cigarette smoking the single most important cause of preventable disease, disability, and premature death in America. Continued interest in the role of the physician, as an exemplar, in promoting changes in the smoking habits of their patients, prompted the Florida committee and other interested physicians to request a review of their current smoking status. This study was purposely designed with basic similarities to the previous study to determine if the physicians have further modified their smoking habits and to gain some new insight into their recent personal health experience as it may relate to smoking.

The questionnaire was printed on McBee (marginal punch) cards with simple check-off blanks to encourage maximum participation and to facilitate processing (Fig. 1). The information requested included medical specialty, age, sex, smoking habits, highest daily consumption of cigarettes, length of time quit if applicable, status of health over the past five years, and any of a specified list of seven smoking-related illnesses.

A letter explaining the study and the questionnaire card were mailed by the Division of Health to 8,736 Florida physicians during the first ten days of December, 1971. By the end of January, 1972, 5,736 completed questionnaires were returned with only 85 not being delivered. Responses from the physicians were excellent and prompt. The 66% response from 1972 compares favorably with the 60% of the previous study.

Careful study of the various specialty groups by age and percent distribution indicates that the distribution of the respondents was not significantly different from the physician population of the state by age and specialty. The mean age of the 1972 respondents is three years older (44) than the 1964 mean age (41), and 4.6% fewer physicians reported general practice as their specialty.

No attempt has been made to study the nonrespondents as the physicians were not asked to sign the cards. Nor was there any attempt made to apply intricate statistical methods to the data.

Among the 5,736 physicians who responded to the questionnaire, 37% never smoked cigarettes; 45% smoked cigarettes but have now quit, and 18% are now smoking them. The noncigarette smokers, those who have quit and those who have never smoked, are 82% of the respondents (Fig. 2). In Table 1 physicians are distributed according to specialty practice and smoking habits.

All the medical specialties report a decrease in the percentage of cigarette smokers except dermatology, which showed a slight increase of 2%; however, the number of dermatologists responding to the 1972 study was one third larger than responded in 1964. The rate for dermatologists now smoking is 21.7% as compared with 19.6% in 1964.

The obstetrician-gynecologists ranked first in the smoking of cigarettes with 25.8%; urologists second with 24.5%, and psychiatrists-neurologists third with 21.8%. On the other end of the scale,

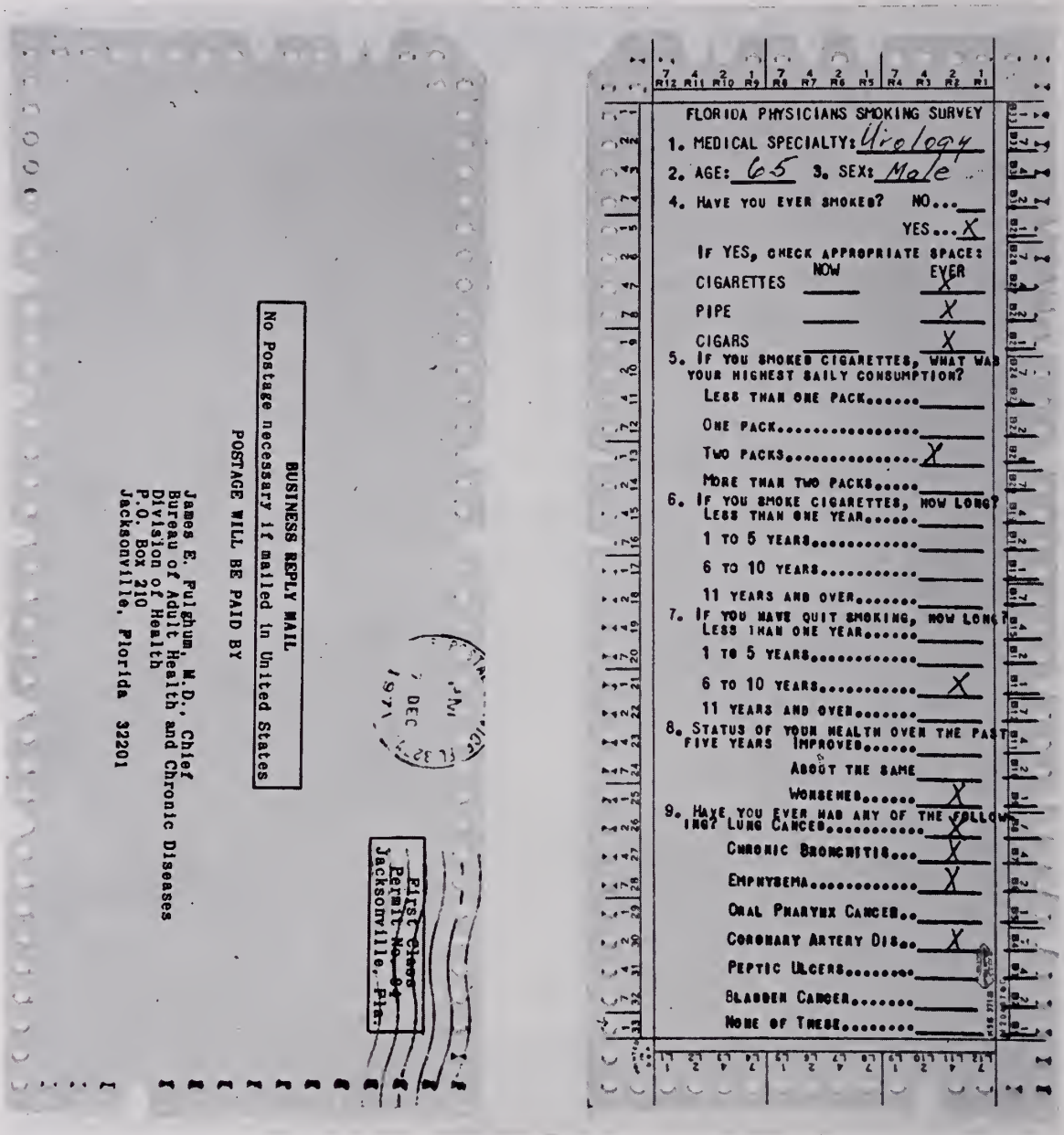


Figure 1

CIGARETTE SMOKING HABITS OF RESPONDING FLORIDA PHYSICIANS 1964 AND 1972



Figure 2

the pathologists were low with 12.6%, and the radiologists next low with 13.1%.

In further answering the questions on smoking habits, the 1972 physicians responded that they have reduced their smoking in all categories: cigarettes, pipes, cigars, and in combinations of two or all three. It seems an important trend to note that cigarette smoking has decreased from 30% in 1964 to 18% in 1972. Pipe and cigar smoking decreased from 28% to 22% over the same period. Smoking cigarettes in combination with other tobacco-smoking products has also reduced from 28% to 6%.

With reference to age, the data revealed: Older physicians are discontinuing the pipe and cigars but the heavy two-plus-pack-per-day cigarette smoker is continuing to smoke. Younger physicians are not starting cigarette smoking but some are taking up pipe or cigars. The mean age of those who have never smoked is 43 years. The mean age of the cigarette smokers and those who have quit is 46 years. Seventy-seven percent of the physicians who quit did so before age 50 years.

Answers from 1,013 physicians indicate they now smoke about 28,290 cigarettes (1,414 packs) each average day. It is a conservative estimate that Florida physicians still spend $1,000 per day ($365,000 per year) on smoking tobacco products! The physicians who quit can account for a reduction of 4,629 packs per day.

The now-accumulated responses from both studies spread across the past 20 years reveal the early recognition of the health hazards of smoking by the physician, triggering the action to quit and the resolve not to start again. In the middle 1950's, Florida physicians were quitting at a rate of about 82 individuals per year, which increased to about 86 per year up to 1960 (Fig. 3). In the 1964 study, the respondents reported that the Surgeon General's report did not significantly change their thinking about smoking. This contention is borne out by the regular progression of the quit-smoking curve, which was 118 per year 1961-1965 and 124 per year 1965-1970. The 1970's begin at 138 physicians per year quitting.

In analyzing the data, two factors become obvious: The more years respondents smoked and the heavier smokers they were, the less successful they were at quitting or they were the least inclined to try. Respondents still smoking are those who have been smoking the longest. The bulk of the remaining smokers have had the habit over 11 years.

Health Status

Nonsmoking physicians report their health improved over three times more frequently than those now smoking. Six percent of the smoking physicians report their health deteriorating as compared to 4% for the nonsmokers (Fig. 4).

Even to physicians, it does not become apparent that smoking is adversely affecting their health until they have been smoking for over 11 years.

Of those who quit: The more they had smoked, the greater change they reported in their health status over the past five years. Of the former heavy smokers (over two-packs-per-day),

TABLE 1.—STATUS OF CIGARETTE SMOKING OF FLORIDA PHYSICIANS RESPONDING 1964 AND 1972 BY MEDICAL SPECIALTY.

MEDICAL SPECIALTY	NUMBER		PERCENTAGE					
	Replies Received		Now Smoking		Quit Smoking		Never Smoked	
	1964	1972	1964	1972	1964	1972	1964	1972
General Practice	851	1143	37.0	20.2	39.0	42.9	24.0	36.9
Internal Medicine	594	1030	26.5	15.3	50.9	48.3	22.6	36.3
Surgery	469	769	25.1	17.3	48.2	46.7	26.7	36.0
Pediatrics	213	349	25.0	16.0	43.3	43.0	31.6	41.0
Ob.-Gyn.	255	368	37.0	25.8	36.6	41.3	26.4	32.9
Psychiatry-Neur.	160	379	37.0	21.8	44.1	42.4	18.9	35.8
Anesthesiology	84	200	27.0	16.5	47.6	45.5	25.4	38.0
Orthopedics	115	235	29.1	17.0	50.1	46.8	20.8	36.2
EENT	206	405	27.1	14.8	45.0	40.2	27.8	44.9
Radiology	124	268	21.1	13.1	34.9	48.1	24.0	38.8
Urology	86	159	40.0	24.5	37.4	45.3	22.6	30.2
Dermatology	60	92	19.6	21.7	56.8	46.7	23.6	31.5
Pathology	84	167	18.5	12.6	45.8	40.7	35.7	46.7
Miscellaneous*	166	172	23.0	14.4	53.9	42.5	23.1	43.1
TOTAL	3467	5736	29.9	17.9	45.1	44.6	25.0	37.5
Percent Respondents	60%	66%						

*Misc. Includes Public Health, Industrial Medicine, Physicial Medicine, and Unspecified.

FIGURE 3

AVERAGE NUMBER OF FLORIDA PHYSICIANS QUITTING CIGARETTES PER YEAR AS REPORTED IN STUDIES, 1964 and 1972

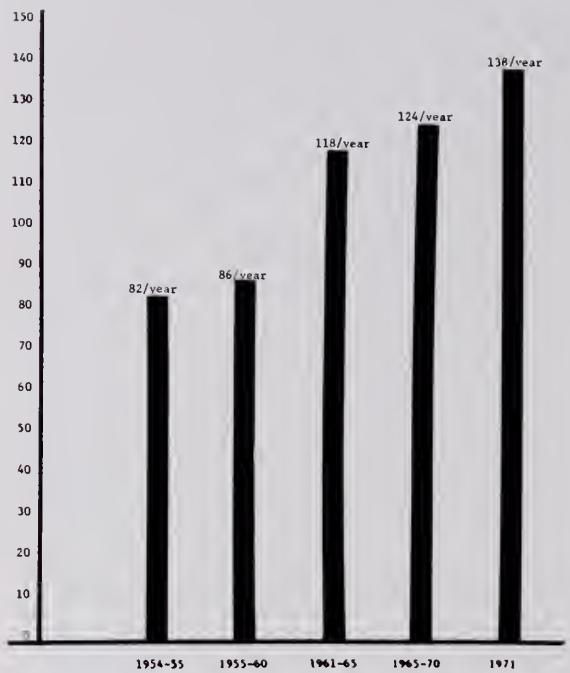


FIGURE 4

REPORTED HEALTH STATUS OF RESPONDENTS, SMOKERS VS. NON-SMOKERS

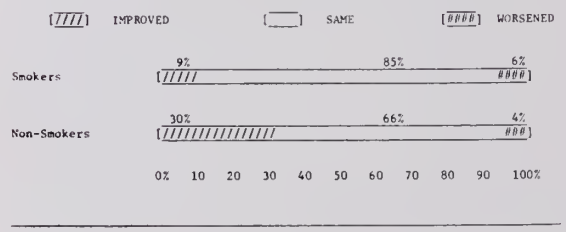
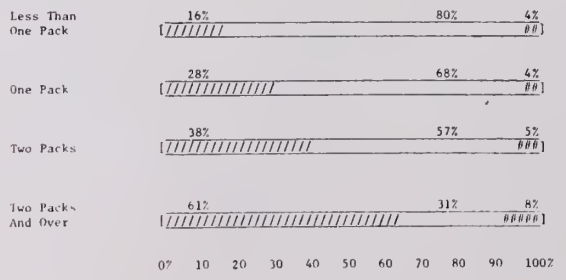


FIGURE 5

HEALTH STATUS OF RESPONDENTS WHO QUIT, BY THE AMOUNT THEY HAD SMOKED BEFORE QUITTING



61% reported their health improved over the past five years after quitting, while the health of 8% worsened. The light smokers reported the status of their health as 16% improved and 4% worsened (Fig. 5).

Of those who quit smoking and reported improved health, the one- and two-packs-per-day smokers recognized the most benefit: 33% each reported their health improved while the light smokers (less-than-one-pack-per-day) and the heavy smokers (over two-packs-per-day) each reported 17% improved.

The longer respondents smoked, the more frequently they reported their health improved on quitting: 16% for less than one year; 18% from one to five years; 27% from six to ten years; and 36% for 11 years and over (Fig. 6). The same trend was reported for those whose health has deteriorated, except to a far lesser degree: from 2% who smoked less than six years to 6% for those who smoked over 11 years.

Introduction to Related Pathology

Most authorities agree that cigarette smoking initiates a disease process by producing progressive pathological changes which may or may not be reversible with the cessation of smoking.[2] Because of the limitation of space on the questionnaire card, only seven of those conditions having a causal relationship or having shown epidemiological evidence of association as a result of the smoking of cigarettes were included. These are lung cancer, chronic bronchitis, emphysema, oral pharynx cancer, coronary artery disease, peptic ulcers and cancer of the urinary bladder (Fig. 7).

The mean age of those respondents reporting one or more of the specified smoking-related pathological conditions is 53 years.

Lung Cancer

There were three cases of lung cancer reported by respondents. All are former cigarette smokers in their sixties (64, 65 and 68) who quit before age 60; two were heavy smokers (two-packs-per-day or more); one was a light smoker. One respondent reporting lung cancer indicated that the cancer was metastatic.

Chronic Bronchitis

One hundred eighty-one physicians reported chronic bronchitis. Five physicians or 2.7% of respondents reporting chronic bronchitis had never smoked cigarettes.

Ninety-seven percent of physicians reporting chronic bronchitis either are now or have been cigarette smokers. Sixty-seven percent were two-or-more-packs-per-day smokers. Seventy-five percent smoked over 11 years.

Emphysema

Twenty-six respondents reported having emphysema. It is significant to note that no emphysema was reported by those who never smoked. Emphysema was reported by seven now-smokers and 19 former smokers whose mean age was 59 years. The mean emphysema victim has not now been smoking for nine years. Ninety-five percent smoked over 11 years, over half (55%) of whom were two-or-more-packs-per-day smokers.

Oral Pharynx Cancer

Out of ten oral pharynx cancer victims, two were under 50 years old; 80% were smokers or former smokers; 20% had never smoked. Eighty-seven percent of the smokers were heavy smokers, all of whom had smoked over 11 years.

Coronary Artery Disease

One hundred seventy-nine respondents reported having coronary heart disease. Seventeen percent of this group were nonsmokers. The mean age of those reporting coronary artery disease was 62 years. Eighty-three percent were smokers or former smokers. Seventy-seven percent of this group smoked over 20 cigarettes per day with 74% smoking over 11 years.

Bladder Cancer

Four respondents reported bladder cancer. Among the respondents, only cigarette smokers and former cigarette smokers have had bladder cancer. There were no cases reported among those who never smoked or among those who smoked only pipe and/or cigars.

It is further interesting to note that only two physicians continued to smoke once lung, oral, or bladder cancer was detected (one oral and one bladder).

Characteristics of Those Answering "None of These"

There were 1,114 physicians who had never smoked who reported having had none of the specified diseases listed; 1,781 former smokers reported they had not had any of the specified diseases.

FIGURE 6

RESPONDENTS (422)
REPORTING IMPROVEMENT IN HEALTH
AFTER QUITTING THE SMOKING
OF CIGARETTES

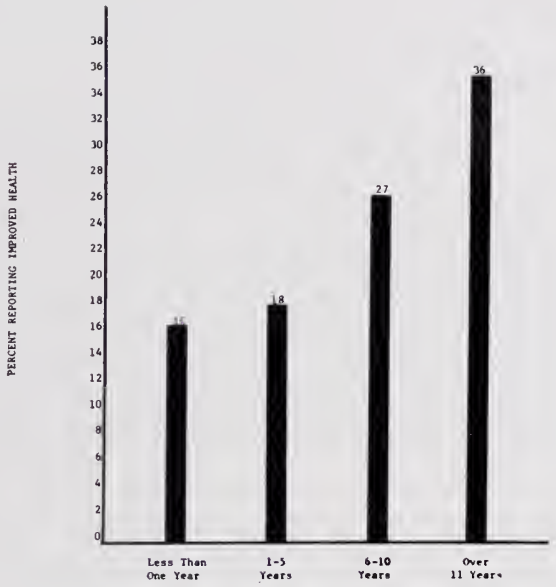
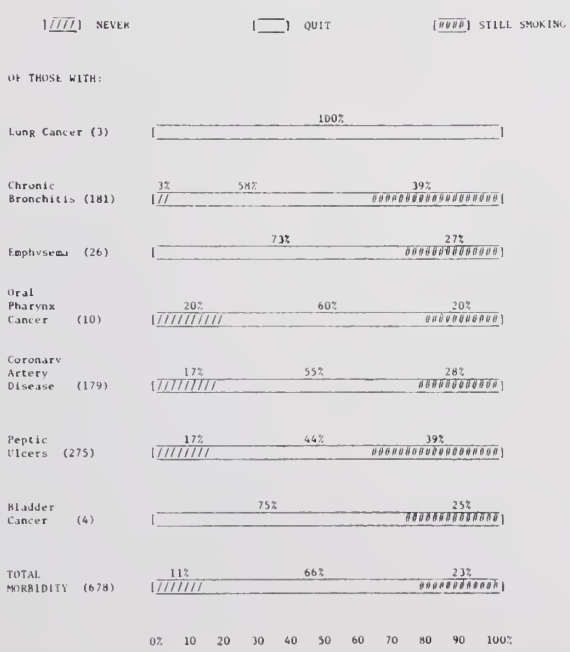


FIGURE 7

SMOKING HISTORY OF RESPONDENTS REPORTING
678 INCIDENCES OF SMOKING-RELATED PATHOLOGY



Seven hundred ninety-five physicians continuing to smoke cigarettes have not yet experienced any of the specified pathological conditions listed in the questionnaire.

Summary

This is a report of a 1972 survey of the smoking habits of 5,736 Florida physicians, 66% response to the questionnaire. Comparison is made between this and the 1964 survey.

Eighty-two percent of the physicians do not now smoke cigarettes as compared with 70% in 1964. Urologists and obstetrician-gynecologists smoke the most cigarettes while pathologists and radiologists the least.

The more years the physicians smoked and the heavier they smoked, the less successful they were at quitting. Many reported that their health improved after quitting.

Of those reporting pathological conditions, most were smokers who had quit. However, some had obviously not quit soon enough. A 65-year-old urologist reported having lung cancer, chronic bronchitis, emphysema and coronary heart disease.

It appears that the physicians of Florida are continuing their responsibility for public education about tobacco and health by personal example.

Acknowledgment

We acknowledge the assistance of the Division of Health in making this survey possible. Especially do we express our appreciation to Miss Debbie Damato of the Bureau of Adult Health and Chronic Diseases for her valuable assistance in preparing this report.

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Dr. Fulghum, Department of Health and Rehabilitative Services, Division of Health, Box 210, Jacksonville 32201.

Steps To Destruction

1. The undermining of the dignity and sanctity of the home, which is the basis of human society.

2. Higher and higher taxes; the spending of public money for free bread and circuses for the public.

3. The mad craze for pleasure; sports becoming every year more exciting, more brutal, more immoral.

4. The building of great armaments when the real enemy is within—the decay of individual responsibility.

5. The decay of religion; faith fading into mere form, losing touch with life, losing power to guide the people.

The average age of the world's great civilizations has been 200 years. Nations progress through the following sequence:

From bondage to spiritual faith; from spiritual faith to great courage; from courage to liberty; from liberty to abundance; from abundance to selfishness; from selfishness to complacency; from complacency to apathy; from apathy to dependence; from dependence to bondage.

In 1976 the United States will be 200 years old.

From the Decline and Fall of the Roman Empire by Edward Gibbon.

Use of Illegal Drugs in College
A Follow-Up Study

W. J. Coggins, M.D., and Joel Lipman, B.S.

Facts are stubborn things; and whatever may be our wishes, our inclinations. or the dictates of our passions they cannot alter the state of facts and evidence. John Adams (1770)

In the fall of 1969 a survey of illegal drug use was conducted in a large state university in Florida and the results were published in this Journal.[1] That study revealed that significant numbers of college students were using illegal drugs, particularly marijuana. A striking feature of the data was the dynamic aspect of the students' behavior in using and giving up the use of marijuana. It was apparent that many tried marijuana and rapidly reached the conclusion that its use was not a rewarding experience. Thus, 49.1% of those students who had used marijuana reported that they no longer used the drug, and half of those ex-users reported that they did not intend to use it again.

Surveys of other populations of young people in high school and college suggested that the incidence of illegal drug use in general and marijuana use in particular might be leveling off or declining in this country. We, therefore, wished to sample this student population a second time to see if, and to what extent, these trends were reflected in Florida.

In April 1971, approximately 18 months after the first survey, a sample of the entire student body was taken by choosing every seventh name from an alphabetical roster of the entire student body. This survey used a simple one sheet questionnaire identical in format to the one used in the first survey. Several questions were reworded to make them more specific. Unlike the initial survey, which consisted of a first mailing and a second (follow-up) mailing, only one mailing was done. Anonymity of responders was again stressed in a letter which accompanied the questionnaire, as well as on the survey itself. In the initial survey questions referring to reasons why the individual never tried marijuana or why he quit using marijuana were left open for the responder to supply. These write-in responses were categorized and the reasons with high frequency were used in the follow-up survey as possible choices of answers to multiple choice questions. Ample space was again provided for the responder to comment or write in reasons not stated in the questionnaire.

A computer program was written to analyze the results according to single frequencies for each answer given, a two way cross of frequencies, and a three way cross of frequencies to determine various patterns of usage.

Results

Of the 2,694 questionnaires mailed, 1,677 were returned. The response rate was 62%. The 1969 survey had a response rate of 62.7%.

In response to the question, "Have you ever used marijuana?" 843 students answered, "Yes." This is 50.3% of the responders in contrast with 30.3% of the "ever-users" in the first survey. Table 1 compares the number of times used as reported in the two surveys. There is a significant increase in the number of students who have ever used marijuana and this also holds true for those using it 10 or more times.

Table 1.—Marijuana: Total Use.

	1969	1971
Once	63 (16.1%)	75 (8.9%)
2-4 Times	108 (28.1%)	128 (15.2%)
5-9 Times	46 (11.9%)	102 (12.1%)
10-29 Times	56 (14.5%)	151 (17.9%)
30 or More Times	112 (29.1%)	387 (45.9%)
TOTAL	385 (99.7%)	843 (100.%)

In the 1969 survey 49.2% of the responders who had used marijuana indicated that they were continuing to use it, while in this survey 62.5% reported continued use. This is a significant increase.

Table 2 compares the students estimate of their frequency of smoking marijuana in the two surveys.

TABLE 2.—MARIJUANA: FREQUENCY OF USE.

	1969	1971
Stopped	187 (50.8%)	312 (37.5%)
Once a Month	82 (22.3%)	192 (23.1%)
Once a Week	45 (12.2%)	116 (13.9%)
2-3 Times per Week	34 (9.2%)	118 (14.2%)
4-7 Times per Week	10 (2.7%)	66 (7.9%)
More than Once a Day	10 (2.7%)	28 (3.4%)
TOTAL	368 (99.9%)	832 (100.%)

These figures indicate that student estimates of the frequency with which they have smoked marijuana has also increased significantly.

For students who have stopped smoking marijuana, time since their last use of the drug may be an important determinant of future behavior. Table 3 indicates that 65.9% of those who indicated they had discontinued its use did so six or more months beforehand.

TABLE 3.—MARIJUANA: TIME SINCE LAST USE.

	No.	%
Less than 1 month	42	(13.5)
Less than 3 months	64	(20.5)
Less than 6 months	61	(19.5)
Less than 1 year	55	(17.6)
Longer than 1 year	90	(28.8)
TOTAL	312	(99.9%)

Frequency and regularity of marijuana use is correlated with age in this population. Figure 1 reveals significantly more frequent use by students in the 17 to 19 year age bracket than in older students. The number of students using the drug once a week or more declines progressively in the higher age brackets.

If age is correlated with marijuana use, then the students' year in college should reflect this. Figure 2 presents the numbers "ever-using" marijuana and those who estimate their use as 30 or more times. This confirms the data in Figure 1 correlating marijuana use with age.

The data on marijuana use correlated with the professional college or school in which the responders were enrolled is presented in Figure 3. For several of the colleges sample sizes were too small to allow valid conclusions to be drawn. Nevertheless, the trends reflected are of interest. Rouse and Ewing[2] in a survey of another university population in the southeastern United States reported high use of marijuana among law students (44%) and medical and health related students (39%).

There is a relationship between place of residence and use of marijuana whether the use is "experimental" or more than 30 times. These designations of area of residence do not indicate that the marijuana use occurs within the residence. The high incidence of use by students residing in the dormitories and fraternity and sorority houses is partly a reflection of the high use of

FIGURE I

MARIJUANA EXPERIENCE BY AGE GROUP

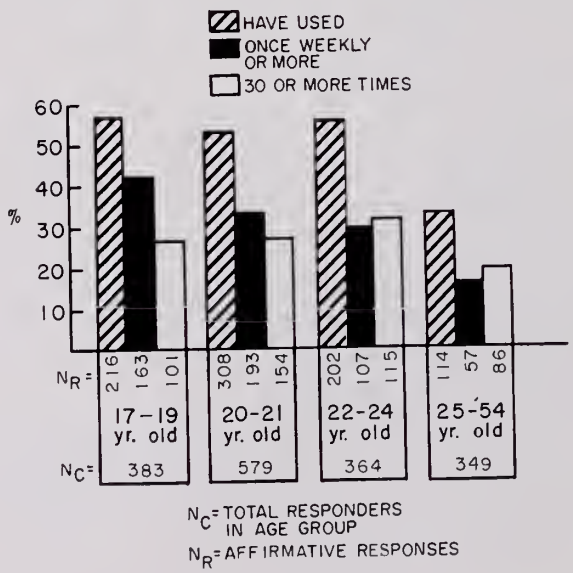


FIGURE II

MARIJUANA EXPERIENCE BY ACADEMIC YEAR

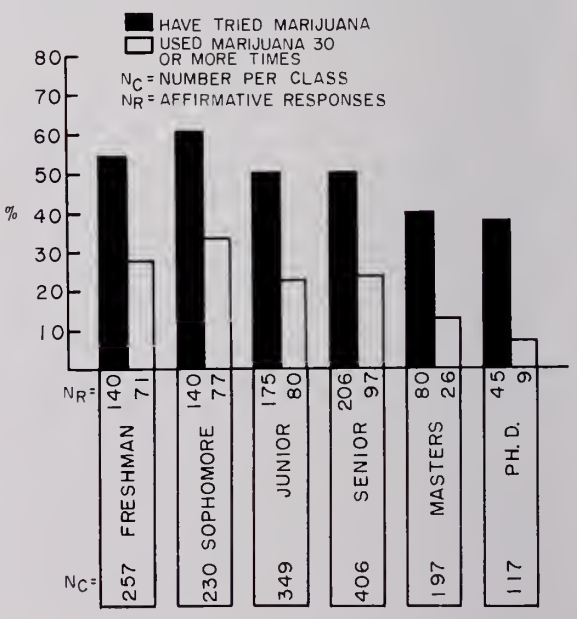
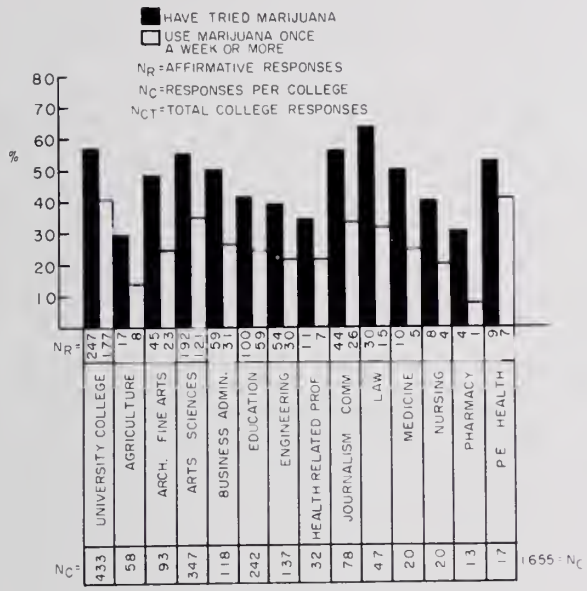


FIGURE III

MARIJUANA EXPERIENCE BY COLLEGE



marijuana by younger students, since freshmen and sophomore students are required to live either in the residence halls or fraternity or sorority houses. Student responders who live off campus would generally be upper classmen and graduate students, as would be the majority of those in married student housing. Table 4 shows the incidence of "ever-users" and 30 or more times users by place of residence.

Comparison of reasons given for not trying marijuana and for quitting its use is given in Table 5. During the 18 months between the two surveys there was much public discussion and some positive action in state legislatures in the country to decrease the legal penalties for possession of marijuana. However, at the time of this survey possession of the drug was still a felony in Florida. In another study of college students reasons for discontinuing marijuana use the major categories of reasons given, and their frequencies, were essentially the same as those reported here.[3]

Although the 1969 survey indicated that students did not view the use of marijuana by their friends as a strong determinant of their own behavior, there is a significant change in this attitude shown here, since over one fourth of the responders list this as a factor in not smoking. The 1969 survey also shows a suggestive difference in the views of male and female students toward the potential harmful physical or psychological effects of the drug, since more females listed this than did males. In the current survey no such differences in response between males and females were present.

It seems quite clear that lack of desire for or interest in the drug is the predominant reason for not using it, even though students view the drug as more available. The high percentage of individuals who continue to fear the potential harmful physical or psychological effects of the drug is noteworthy. We did not correlate this response with attitudes toward tobacco and alcohol, however the study shows high group correlation between use of marijuana, tobacco and alcohol. Regular use of cigarettes was reported by 32.7% of the 822 "ever-users" of marijuana who answered this question and 51% of the "ever-users" report regular use of alcohol. In the non-marijuana users 10.7% report regular use of cigarettes and 34.8% report regular use of alcohol.

Is the increase in prevalence of marijuana use reflected in the use of other drugs? Table 6 shows the comparisons between the two surveys for several of the drugs of particular interest in a college population. No attempt was made to define or limit the responders' interpretation of the term "regular use." The slight decline in reported use of barbiturates is not statistically significant and may be attributed to the fact that this survey asked students to omit reporting those drugs

TABLE 4.—MARIJUANA USE VS COLLEGE RESIDENCE.

	N TOTAL	HAVE TRIED MJ		USED MJ 30 OR MORE TIMES	
		No.	%	No.	%
Residence Hall	508	263	51.8	114	22.4
Fraternity & Sorority	120	64	53.3	40	33.3
Married Student Area	85	29	34.1	8	9.4
Off Campus	910	470	51.6	219	24.1
Parents' Home	46	11	23.9	3	6.5
TOTAL	1669*	837		384	

*8 responders did not indicate place of residence.

Table 5.—Reasons:

	For Not Starting Marijuana				For Quitting Marijuana			
	1969 N=885		1971 N=836		1969 N=189		1971 N=312	
	No.	%	No.	%	No.	%	No.	%
No desire, need or interest	498	56.3	745	89.0*	99	52.5	266	85.3*
Fear of legal consequences	208	23.5	325	38.7*	62	32.8	155	49.7*
Fear of harmful physical and/or psychological effects	293	33.1	594	71.0*	36	19.0	125	40.0*
Drug not available	183	20.7	78	9.3*	27	14.3	29	9.3
Friends don't use	44	5.0	229	27.4*	12	6.3	34	17.3*

*P=<.01

Table 6.—Other Drugs Used.

	1969 N=1272		1971 N=1677	
	% Ever-Used	% Use Regularly	% Ever-Used	% Use Regularly
Cigarettes	62.7	20.7	69.6†	21.9
Alcohol	89.7	46.0	95.6*	43.0
Barbiturates	9.9	0.6	8.6†	0.4
Dexedrine	22.6	2.4	30.9**	1.6
Methedrine	3.9	0.2	12.1*	0.4
"Mescaline" or peyote	5.6	0.6	15.0*	0.6
"THC"	1.8	0.0	11.6*	0.4
LSD	5.0	0.6	11.6*	0.6
Opium	3.0	0.1	6.8*	0.1
Cocaine	2.0	0.2	4.1	0.3
Heroin	0.9	0.1	0.7	0.1

*P=<.01 **P=<.02 †P=<.05

which were prescribed for them by a physician, whereas the 1969 responders were not so instructed. Despite this proscription, there was an increase in the percentage of students who had taken Dexedrine or Methedrine one or more times. The percentage of regular users of Dexedrine declined slightly to 1.6%. Of the "ever-users" of marijuana 48.6% had used an amphetamine one or more times. The significant increase in percentage of students reporting use of "mescaline" or peyote, "THC" and LSD are further reinforced by our finding that 30.4% of the marijuana "ever-users" had used at least one of these hallucinogens one or more times. By contrast only 0.7% of the non-marijuana users reported experimentation with a hallucinogen. However, other studies have shown, as this one does, that very few of these marijuana users go on to regular use of the hallucinogens, as shown by the percentages of 0.6%, 0.4% and 0.6% for regular use of these drugs in Table 6.[4] If marijuana does, in fact, lead users to regular use of other illicit drugs one would expect to find a proportionate increase in repeated use of those drugs as the percentage of marijuana users goes up.

Assays of street drugs in the city where this study was done have repeatedly shown that drugs identified by the seller and user as "mescaline" or "THC" have consisted of other drugs, usually containing small amounts of adulterated LSD. For this reason, reports of use of these two drugs must be interpreted as an intention to use an hallucinogen, rather than an actual use.

The very low number of students (11) reporting heroin use in 1969 was confirmed in 1971. In the interval between the two studies a methadone maintenance program was established in the city. Past histories of heroin addicts admitted to this program revealed very few who had been students at the university and none of these had been able to maintain student status while addicted to heroin, although several individuals in the program had previously been students while using heroin on less than a daily basis. Heroin use is not a significant problem in this population.

Comparison of "drugs ever used" between male and female students showed little difference except for the hallucinogens and heroin. Female use of tranquilizers has been found higher than male use, both for legally prescribed and illegally obtained drugs in several studies. The results in Table 7 confirm this.

Table 7.—Sex vs Drugs Ever Used.

	Male	Female
Marijuana	52.8%	46.2%
Tranquilizers	14.9%	22.6%
Barbiturates	9.2%	7.5%
Dexedrine	30.7%	31.3%
Methedrine	12.7%	11.0%
"Mescaline"	16.1%	13.4%
"THC"	12.5%	9.9%
LSD	13.2%	8.8%
Opium	7.1%	6.2%
Cocaine	4.5%	3.3%
Heroin	1.2%	0.2%

Summary and Conclusions

This study shows a definite increase in the incidence and prevalence of marijuana use between the fall of 1969 and the spring of 1971 in the population study. This behavior is not reflected in a marked increase in use of other drugs. Other studies have shown positive correlations between a number of social factors and marijuana use, such as the socioeconomic status of the parents, permissive parental attitudes, the drug using behavior of the parents, alcohol use of parents and urban versus rural place of residence. These factors and others are undoubtedly contributory factors in the drug use of this population.

Marijuana use was most prevalent among freshman and sophomore students at the time of this survey. There was significant difference in prevalence of use by students in various colleges and professional schools within the university.

Several variables affect the marked differences in use rate between the professional schools. Since usage is higher among younger students this fact will be reflected in the data from the colleges having the higher proportion of freshmen and sophomores enrolled. Peer group pressure is undoubtedly a factor in these high-user groups. It is noteworthy, however, that in those professional schools in which the graduates may have significant impact on societal values, such as education, law and medicine, the number of once a week or more users is quite significant (24%-30%). It is apparent, even now, that regular use of the drug is by no means restricted to any well defined group within American society, such as college students, but is found among all socioeconomic groups and occupations.[5]

Differences between male and female students both in use of and attitudes about the drug were minimal.

The relatively high percentage of "ever-users" reported here should be viewed in the perspective of the results of a national survey conducted for the National Commission on Marijuana and Drug Abuse which indicates that 40% of the 18 to 21 year olds in this country have tried marijuana.[6]

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Sick? Yes, but not on Saturday

A doctor, called to the home of an elderly man who was seriously ill, complained because it was a Saturday morning.

The patient's sister said the man, who had a heart condition, had not been seen by the doctor for nine months.

"Once a year is too much," the doctor told her, and said she should consult someone else.

A week later the patient's condition deteriorated. His sister took 90 minutes to contact the doctor by telephone. He did not call, but sent an ambulance.

Four days afterwards the man died in hospital.

For not visiting and treating the patient as required, the Inner London Executive Council has fined Dr X £75 and censured him.

Reprinted from the London News of the World, March 26, 1972. Courtesy of W. A. VanNortwick, M.D., Jacksonville.

Automated Health Testing and Medical Care

Ewen M. Clark, M.B., Ch.B. and Mario Ariet, Ph.D.

Abstract: This paper briefly reviews the short history of automated multiphasic screening programs, commenting on some of the difficulties which were encountered in their development and continuing operation. Three areas of difficulty are identified which are common to many automated health testing programs. Each of these areas are discussed and suggestions are offered to minimize these difficulties. The design for one possible system is offered which may better meet the needs of the patient and the medical profession in seeking and providing quality medical care.

The future of automated health testing remains uncertain. It would seem appropriate, therefore, to examine the actual and possible roles within the present framework of medical care.

It is currently fashionable to describe health care delivery as a nonsystem. This statement is certainly not accurate. It is a highly complex system which may beg description, yet physicians can and do operate within its structure. Whether the present system is a desirable one is a matter for considerable debate. Discussion should be directed to developing a medical care system which can meet the needs of all and be subject to evaluation, enabling the many excellent qualities of the present system to be retained. It is also essential to include within the system some evaluative measures to safeguard the high quality of the practice of medicine within the constraints of cost containment.

Automated health testing can make a sizable contribution to the present medical care system and help to develop new systems.

The early screening centers were established with the primary objective of case finding. Case finding is laudable, provided adequate diagnostic and therapeutic services are available to cope with the deluge of new patients which results from such a program. In these early programs insufficient attention was paid to their effect on the existing medical care system. Typically these programs were designed and located to serve the lower socioeconomic groups of the inner city populations. Patients were dumped into a medical care system already bursting at the seams, and served to compound many times the health delivery problems. Perhaps the unwitting patient, seeing this as an opportunity for a free health check up, gave the name of a physician selected from the yellow pages as his personal or family physician to whom the report should be sent. Not surprisingly considerable discontent ensued from the unhappy encounter between the physician and the unsolicited report.

When a multiphastic screening center is successful in attaining its case finding objectives, there should be a continuing decline in the number of new cases identified—at least until a plateau is reached which nearly matches the annual incidence of the disease being sought. As this point is approached the cost of finding new cases increases, and the program may become uneconomical from a health resource standpoint.

It seems unreasonable then that these centers would have anything but a limited duration of utility in any one population center. Indeed experience appears to indicate the average duration of utility is somewhat shorter than originally anticipated, as witnessed by the closing of some of the Public Health Multiphasic Screening Centers.

Examination of the characteristics of automated health testing centers which appear to be providing a useful and demanded service may be the best way of discerning their developing role in the medical care system. The Multiphasic Screening Centers, operated by the Kaiser-Permanente Foundation in Oakland and San Francisco, each screen in excess of 20,000 patients

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annually.[1] Recently an experiment to evaluate a new function for multiphasic screening has been undertaken.[2] The patients are sorted on the basis of the multiphasic examination for care in one of three modalities of health care, which includes sick patient care by physicians, chronic disease monitoring and surveillance by nonphysician health professionals, and preventive and health educational services. Few areas in the United States have managed to develop a comprehensive health system. The Cleveland Community Health Foundation struggled for four years with an inadequate financial base, amongst other problems, prior to amalgamating with the Kaiser-Permanente group in 1969.[3] Experiences such as this indicate this type of system does not have universal acceptance within the medical profession, nor does it offer total satisfaction to all patients.

A highly successful program has been established by the Public Health Service for some residents in Memphis and surrounding counties.[4] This service is basically for the care of indigents. The core of the program is the provision of continuing chronic disease surveillance by nurse practitioners operating within specific protocols for each disease. The patients enter the system through a screening center which determines the need for individual diagnostic work-up. On completion of the diagnostic phase, the patient has routine follow-up care by the nurse practitioner.

The Latter Day Saints Hospital in Salt Lake City, Utah, recently started to perform broad spectrum health testing routinely for all patients being admitted for inpatient care. The examination is part of the admitting process; the necessary changes in space utilization and laboratory routines were accomplished by administrative fiat. While no firm evaluative data are yet available, the introduction of this routine is now considered to be producing a benefit to both patient and medical care.

The common thread which runs through the operations described is the integration of the service within a well defined population. The administrative decision to utilize automated health testing, while requiring the integration of the center into the overall system, also secures an identifiable patient volume for the center. By doing this, economies can be effected through efficient scheduling of patients, and optimising the use of the testing center staff. The decision to implement this course of action is difficult, since the existing fiscal equilibrium will be upset and sources of income will be changed. Recent reports indicate that physicians are not financially harmed by these changes.[5,6]

Each of the examples previously described are operating with clearly defined purposes and objectives and service a closed population. This in no way detracts from their usefulness within these programs since they obviously meet their stated objectives. Review of these examples of automated health testing indicates three features which must be considered essential ingredients of a successful center. These are: (1) integration within the existing local health delivery system, (2) provision of sufficient diagnostic and follow-up services for patients tested at the center and (3) the report must have a level of utility which is self-evident to the physician and the center, a mode of operation which is satisfactory to the patient.

Integration

Virtually all health delivery systems have similar components. These components consist of patients seeking medical care, a hospital providing both inpatient and outpatient services, physicians in private practice and certain state or private health agencies. In addition, there may or may not be a state or federal institution in the locality. These components are present, and utilized, in varying proportions within different systems.

Prior to establishing an automated health testing center it is necessary to sample these components to determine the likely utilization rate from each. This information is necessary to estimate the required volume capacity and possibly the location of the center. The location of the center need not necessarily be in the area of maximum utilization. Of more importance is the urgency of the report and the ability to deliver the report as speedily as possible. Ideally all elective admission to hospitals can be through an automated health testing center. This has the advantage of standardizing routine tests. The existing laboratory services can be geared to perform these tests with minimal scheduling difficulties, allowing the attending physician to know with reasonable certainty when the results will be available. While certain tests performed routinely at the center may be redundant for one patient they may be highly relevant to another. By performing all these tests routinely one step in the initial evaluative process can be eliminated, and the overall cost to the patient substantially reduced.

For specialty outpatient clinic patients automated health testing has less routine value; however, in certain instances such as in chronic disease monitoring the regular review of other physiological data will aid the physician by alerting him to abnormalities which have appeared in a surreptitious fashion and may have been overlooked.

For the busy physician in office practice the utilization of automated health testing can enable him to provide a more efficient service. New patients coming to his practice can have a data base established prior to being seen, relieving him of some tedious routine work.

In industrial health programs automated health testing provides an excellent tool for the early recognition of known environmentally induced disease. For example, routine chest x-ray and spirometry testing will identify pneumoconiosis in coal miners at an early stage of the disease process. In addition, the identification of environmental or industrial hazards can be facilitated. The prevalence of asbestosis in construction workers could have been reduced much earlier had the disease and its etiology been linked sooner.

Finally in the field of integration it is highly desirable to standardize a record keeping system for the patients. The problem oriented record system has the advantage of being computer compatible, but is not to the liking of all physicians. Where automated health testing is integrated into a health delivery system, however, it is, if not essential, then highly desirable that the majority of the physicians have a common record system which can be complemented by the center's report.

Follow-up

The provision of adequate follow-up services is essential when the establishment of an automated health testing center is planned. Obviously when a physician refers a patient the follow-up care is guaranteed. However, many indigent patients have no personal or family physician. The evaluative and diagnostic services available to them may be inadequate to cope with the increased volume if large numbers of these patients are tested. To prevent overwhelming the follow-up services two possibilities can be considered. Setting up a special clinic for seeing these patients is one very obvious solution. However, difficulty in staffing may preclude this as a practical choice. An alternative, but as yet barely exploited solution, is to program sophisticated advice rules into the computer. Considerable information regarding the general function of the different physiological systems can be gleaned from a review of present symptoms which the patient has and also from the results of the physiological measurements. By programming the computer to recognize these parameters and classifying them on a physiological system or organ function basis, a "problem oriented" group of biochemical tests and additional examination procedures can be constructed for each patient. This additional information would be collected prior to the patient seeing the physician. Certainly from a theoretical standpoint the diagnostic process would be speeded up to a considerable extent, allowing for a very efficient use of physician and patient time.

Inevitably the criticism of impersonal medical care will be hurled at this concept. However, less personal care may be preferable to no medical care. It is well to note that movement in the direction of customized biochemical profiles (organ panels) has already taken place.[7] Provided some degree of automation becomes available for performing the organ panels then a rapid and indepth evaluative report will be available to the physician at first contact with the patient in the form of a general review of systems and a second level investigation of presenting symptomatology. It would seem entirely reasonable that this would allow the physician to evaluate effectively a problem and develop a treatment plan for many of his patients at the first visit. In addition, the patient would not be delayed in obtaining treatment.

Utility

The term utility naturally covers these considerations, but goes beyond them. The speed and manner in which the report is presented is an important aspect of utility. The report must be presented in an intelligible, concise and readable form. As mentioned previously, compatibility with existing medical records is highly desirable. The speed with which the report can be delivered is crucial. A symptomatic patient does not want to be delayed in obtaining treatment for his malady. To provide this form of service, two features are essential. Firstly, the testing system must be an integral facet of the health delivery system. Secondly, and of equal importance, the testing system must have the capability of producing the report within a few minutes of the patient completing the testing sequence. To achieve this the testing system must be on-line to the computer; making it feasible for the computer to provide the report

instantly and where appropriate to formulate the on-line decision advice rules to obtain further problem oriented tests prior to consultation with the physician. The time involved in this whole procedure would not normally exceed two to three hours, the same amount of time not infrequently spent sitting in a waiting room.

Additional niceties of the report, contributing to its utility, could be the establishment of at least parts of a problem list for each patient based on historical, symptomatic and test results. This may aid the specialty physician, in areas outside his area of major expertise, in overall patient management.

Conclusion

Automated health testing is presently in its infancy. The contribution which this technique can make to the delivery of health care will be dependent on the acceptance by the medical profession and limitations of development funding. The question whether this technique is here to stay appears to have been answered by the increasing number of centers throughout the country. The next five years or so will hopefully determine the optimal manner in which to integrate automated health testing into the health delivery system.

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*Koch-Weser, J., *et al.*: *Arch. Intern. Med.*, *128*:399, 1971.

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Special Articles

Abortion is Not the Answer

Matthew J. Bulfin, M.D.

The book, "The Death Peddlers," an edited report of the Symposium on Implementation of Abortion held at U.C.L.A. in January 1971, aptly illustrates the dramatic departure over the last five years from the traditional medical position on abortion. For thousands of years the medical prohibitions and ethical disinclinations toward abortion are well recorded. The medical aversion to attacks on unborn life were clarified for modern physicians by the 1948 Declaration of Geneva which followed the Nuremberg Trials. While the memories of Warsaw, Dachau and Buchenwald were still vivid and indelible to most of the civilized world, destruction of the unborn as a means of achieving a happy, comfortable family life, controlling world population or eliminating illegitimate births was not seriously considered or even thought of by most people in the 1940's and 1950's.

In 1969, by a margin of only one vote, the New York State Legislature passed its current liberalized abortion bill. In the two and one half years since its enactment, over 400,000 abortions have been carried out. It is possible that never before in world history has the casting of one vote caused the extermination of so many human beings.

New York State points with pride to its liberalized abortion law. It even permits widespread advertising for customers. Thousands of unsolicited flyers and brochures have fairly inundated doctors' offices throughout the country. Much of the material reeks of flagrant huckstering and is of varying degrees of offensiveness. The prices quoted for "Pregnancy Termination" rise proportionately with the weight in grams of the fetus. A "sucking out" procedure, for instance, for an obviously small embryo is $200 while a "salting out" of a 500-700 gram fetus could cost as much as $400-$500. While New York State allows these Exterminating Centers to advertise for their customers, there is no mention made of the victims.

Some abortion centers in their pitch for customers give the impression that coming to New York for an abortion can be a gala holiday associated only with a minimum of inconvenience and practically no discomfort. One such abortion facility in its color illustrated brochure shows the "spacious waiting rooms for family and friends" and gives such items of information as the times of limousine service from LaGuardia and Kennedy Airports. Among the instructions to the patient are such as "Bring a sanitary belt." Another "It is advisable but not essential, to have someone accompany you." All of which can lead the unsuspecting patient to believe that having an abortion is about as dangerous as getting a haircut.

In New York State alone in its first year of legalized abortion experience, 62 live fetuses were sucked out, cut out, salted out or scraped out; 56 subsequently died in varying conditions of indignity. Six of this number are evidently still alive as the New York Health Department could not find death certificates for them. Are these complications of abortion? In such cases the attending physician has badly miscalculated the uterine size as will certainly happen to a physician of meager experience or one who fails to take the proper time to evaluate the patient and her condition.

In Maryland, an abortion case, resulting in the live birth of a baby who was placed in a refrigerator and later died was investigated by

the U.S. Attorney's office. The finding of the hospital committee investigating the catastrophe was that the physician made a poor judgement in his original estimate of the gestation period. In 1970, in Maryland, three maternal deaths occurred as a direct result of the salting out type abortion procedure.[1]

Abner Weisman, M.D., in a letter to the Journal of the American Medical Association published in the September 13, 1971 issue, describes his office building in New York as the largest abortion center in the United States having legally performed 40,000 abortions in one year. Two clinics, each occupying an entire floor, worked incessantly around the clock. Operating doctors usually rotated to avoid the syndrome of "abortion fatigue."

At the annual meeting of the American College of Obstetricians and Gynecologists held in Chicago in May of this year, the stories were circulating that first and second year residents in obstetrics and gynecology in some of the New York hospitals were being offered $4,000 monthly to help staff these centers. It is not surprising that horrendous medical complications do occur. According to New York State Health Department records during the first year of the liberalized abortion law, 14 women died while receiving abortions. It is certainly possible that there may have been more deaths as a high percentage of women leave New York to return to their home states where their complications would then occur.

The types of complications being seen and reported are startling. With the new technique of saline amniocentesis or salting out, the preferred method of extermination at 20-24 weeks gestation, the incidence of complications has been reported to be 20-24%. In one such case,[2] the physician failing to diagnose an intrauterine twin gestation, injected the hypertonic saline into the amniotic sac of only one twin with the result that the mother gave birth to one dead twin and one alive. The heavy salt solution usually causes the fetus affected by it to convulse and die in the uterus before expulsion. Complications with this salting out method have also been fatal to the mother as evidenced by reports of recent maternal deaths from inadvertent injection of the hypertonic solution directly into the mother's blood stream.[3]

The vacuum curettage or sucking out of the uterus for abortion purposes has its own special problems. Perforation of the uterus and aspiration of the bowel into the apparatus have been reported. Inadvertent but sudden suction of large quantities of blood from the uterine circulation may occur, causing a shock-like catastrophe. A case report in Obstetrics and Gynecology—June 1972—of an air embolism described how the misconnection of the tubing to a vacuum machine caused air under pressure to be introduced into the uterus during attempted termination of pregnancy by intended vacuum aspiration. The mother subsequently died.

The latest figures from Great Britain reveal that maternal deaths occur four times as frequently with abortion as with pregnancy if allowed to progress to its conclusion.[3] Postoperative hemorrhages occur in 10-20% of patients aborted by suction curettage requiring readmission and hospitalization.

At the 1970 White House Conference on Children and again at the AMA House of Delegates meeting in the same year, the resolution declaring the "right of all children to be born healthy" was adopted. It's most difficult in New York these days to be born healthy. Doctors are being paid sizable sums to cut up unborn fetuses with curettes, poison them with salt solution, suck them out with vacuum aspirators or surgically remove them from their mother's womb to be left in all probability to die. The abortion proponents after having exterminated hundreds of thousands of pregnancies in this manner have subsequently seen fit to report their findings that wholesale abortions apparently cause a reduction in infant deaths and actually improve perinatal salvage.[4] Specious reasoning at its worst. It's great to die as a fetus before you can get old enough to die as an infant! It can also be said that the Viet Nam War prevented 50,000 American boys from getting cancer.

Reports from the New York abortion centers would also lead the unwary reader to believe that the psychic trauma of this procedure is minimal. Not so, in my experience. I have personally cared for about 20 patients who were aborted in New York since the inception of its liberalized law. I have yet to see one who was not deeply affected by the experience. "Brutal," "dehumanizing," "wouldn't want my dog to have one" were some of the comments of these girls. Recriminations, deep guilt, loss of self-respect were some of the feelings and symptoms encountered. Some of the single girls I saw expressed strong desires to marry, conceive and bear a child. One girl did just that—she married, became pregnant and

bore an infant to replace the one she felt she destroyed. It is obviously easier to scrape the baby out of the mother's womb than to scrape the thought of that baby out of her mind.

Abortions in New York State bring estimated revenues of $80 million yearly and two over the counter stocks are being pushed as speculation long term capital growth on the basis of mushrooming abortion revenues, according to an article by Howard Eisenberg, "The Mad Scramble for Abortion Money," in a recent edition of Medical Economics.

More and more concerted efforts are being made to force this lucrative atrocity on us.

In the June 1972 issue of the Journal of Reproductive Medicine, Robert E. Hall, M.D., a leading proponent for abortion liberalization, states incredibly that "medical attitudes will have to change. The performance of abortions must be recognized as a social responsibility on the part of the obstetrician. This writer looks forward to the day when religious, emotional and political pressures subside sufficiently to permit us to regard abortion as simply a medical means of dealing with unwanted pregnancies."

The commandment, "Thou shalt not kill," has been with us from time immemorial.

Within tort law, modern scientific knowledge of fetal life has worked a dramatic revolution so that it is now clearly recognized that the unborn child in the path of an automobile is as much a person in the street as the mother.

In 1959 the United Nations unanimously adopted a "Declaration of the Rights of the Child" to supplement its "Universal Declaration of Human Rights." An essential reason for this supplement was clearly stated in its preamble, namely, that the "child by reason of his physical and mental immaturity, needs special safeguarding and care, including appropriate legal protection before as well as after birth."

The most recent discoveries in embryonic and fetal medicine allow us to know that from its very first day the unborn child is a complex and rapidly growing organism with its own unique genetic endowments. By the end of the first month the child completes the period of relatively greatest size increase and the greatest physical change of a lifetime. The month old embryo is 10,000 times larger than the fertilized egg. At two months the brain sends out impulses that coordinate the functions of the other organs and it has been possible to record individual electroencephalogram readings of brain activity. Since the absence of electroencephalogram activity is taken as a sign of death, why do we not consider signs of brain activity in the developing fetus as evidence that human life is present?

Let us not allow Florida to become another state that will sentence a half million unborn to total destruction. Let us instead pay heed to the past centuries of Judeo-Christian ethics, morality and justice when the life of the unborn was protected. How many of us would be here today if our legislators of 50 years ago had authorized death sentences to the fetus by voting the abortion on demand ticket? The Playboy Philosophers, the Women's Libbers and the other hedonistic cults would be short on members now if the women who mothered them had their feticidal tendencies.

If the unborn can be killed in the womb any time the mother decides he is not wanted, what prevents us from exterminating the aged, the sick, the mentally or physically disadvantaged or members of objectionable minority groups when their lives become a burden to others?

In past years when the back room abortionist was convicted, he lost his license to practice medicine and faced a stiff prison sentence. As Rabbi Phineas A. Weberman recently pointed out in a letter to the Miami Herald, we now appear to be legalizing murder and allowing it to be committed by qualified professionals.

Abortion is an atrocity. Society must present a better solution than this.

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Dr. Bulfin, 4701 North Federal Highway, Fort Lauderdale 33308.

We can never do a kindness too soon because we never know how soon it will be too late.

Irish Hospitals

Raymond S. Roy, M.D.

Abstract: After World War I sources of charitable donations were greatly diminished and costs were rising greatly. Irish Hospitals were in danger of curtailing activities and, in some cases, being forced into bankruptcy, prior to the initiation of the Irish Hospital Sweepstakes. The Sweepstakes have enabled all hospitals in Ireland to be upgraded with new equipment and improved facilities with modern equipment by over 200 million dollars being granted to participating hospitals. Hospital services now compare very favorably with some of the best facilities in large cities in other countries. Joseph McGrath, a successful businessman and former Cabinet member, as the Irish Hospital Sweepstakes' first director, is credited for the initial groundwork.

Historically the various religious organizations provided care for the sick in Ireland. Following suppression of monasteries in the reign of King Henry VIII, 1509-1547, very little was done to provide for their housing and care. In the beginning of the 18th century, however, the sick-poor began to attract the attention of the government and in 1703 St. Kevin's Hospital on James Street in Dublin, which still exists, was started through legislation as a foundling hospital and work house. Subsequently many other county infirmaries were set up and in 1923 the terms "work house" and "county infirmary" were replaced by "county home," "county hospital" and "district hospital" under control of local authorities. These institutions were financed by taxation. The voluntary hospitals depended upon donations and legacies.

Had it not been for the Irish Hospital Sweepstakes beginning in 1930 many voluntary hospitals would have been forced to curtail activities and, in some cases, been bankrupted into extinction. Over the past 40 years, vast capital improvements have been carried out, both in voluntary and local authority hospitals, which could not have been achieved without funds obtained through the sale of Sweepstake tickets.

Background and Benefits

After World War I sources of charitable donations were greatly diminished and at the same time costs were rising at an unprecedented rate. Most hospitals were in serious need of reorganization after years of literal hand-to-mouth existence. Because of this urgent need six voluntary Dublin hospitals combined for the purpose of running a Sweepstake. This initial venture, entrusted to Hospitals Trust, Limited, was a remarkable success. As a result 17 additional hospitals sponsored the second Sweepstake. Thirty-four hospitals promoted the third one and within a year these three Sweepstakes resulted in the distribution of 1¼ million pounds or $3 million.

With the prospect of bankruptcy averted, participating hospitals could look forward to sorely needed new construction and the purchase of equipment to modernize and improve the existing institutions.

In 1931 the government decreed that proceeds from further Sweepstakes should be divided two thirds to voluntary hospitals and one third to local authority hospitals. For the next five years, Irish Hospital Sweepstakes continued to grow not only in Ireland but in many countries including the United States. With World War II, 1939 to 1947, there were severe limitations on distribution of tickets and, therefore, a natural diminution in proceeds. The Sweepstake scheme continued to maintain a fair amount of revenue, however, so that hospitals could maintain the status quo.

In the period 1930 to 1968 more than $200 million was granted to participating hospitals in accordance with government legislation. In 1970 the additional incentive for the Sweepstake was a special prize of 200,000 pounds which was won by a ticket holder in Canada.

In addition to direct benefits to the hospitals, there have been a number of side benefits such as medical research, libraries, district nursing service and employment of a large staff of widows and others who otherwise would have found it difficult to obtain similar work.

Among the more outstanding tangible new equipment obtained from distribution of Sweepstake funds, particularly between 1956 and 1969, has been a cardiopulmonary unit at the Royal City of Dublin Hospital, a new pathology laboratory at St. Patrick-Dunn Hospital, and a magnificent 455-bed teaching hospital at Elm Park replacing the old St. Vincent's Hospital at St. Stephen's Green. St. Luke's Hospital has been supplied with a cobalt and isotope unit and Jervis Street Hospital with a renal dialysis unit in addition to a new operating theatre suite and drug addiction unit.

Dublin serves as a national center for training paramedical personnel in addition to hospital administrators and other necessary staff. Hospital services compare very favorably with the best facilities in other large cities and are continuing to develop with the aid of the Hospital Sweepstake scheme which has provided such effective aid over the past 40 years.

Many people have been involved in the Sweepstakes but Joseph McGrath, its first chairman and managing director, is credited with much of the initial groundwork. He is credited also with reviving the craft of Waterford glass, has served as a Cabinet minister, bred Irish horses and been successful in the business world.

▶ Dr. Roy, 160 Okeechobee Boulevard, West Palm Beach 33401.

Good Samaritan?

Physicians Have a Responsibility Which Cannot be Abrogated

One year ago this month, a seven-year-old boy, while crossing a street on the western edge of the city, was hit by a car. He was severely injured and thrown approximately 100 feet by the impact. A physician happened to be driving past as a crowd was forming around the boy.

I am not clairvoyant enough to know what went through that physician's mind, but I am sure many physicians would have questioned getting involved. It would mean being late for whatever appointment he was trying to keep. There was also the question of medical-legal liability. Would that act of mercy expose this physician to a possible malpractice suit if all did not go well? I can imagine many rationalizations of why not to get involved.

Yet, that physician did get involved. And it was his involvement that saved the boy's life. The boy, apneic from a severe cerebral contusion and with airway obstruction due to blood in his oropharynx from a fractured jaw, required immediate medical attention. That boy's life was saved because that physician became involved.

Yet isn't this the real role of the physician, to respond to the medical needs of the patient? The victim of an automobile accident certainly may need immediate medical attention.

That accident has certainly affected my thoughts on giving assistance at the scene of an accident because that seven-year-old boy of a year ago, is my eight-year-old son.

R.H.F.

Reprinted from St. Louis Medicine, March 22, 1972.

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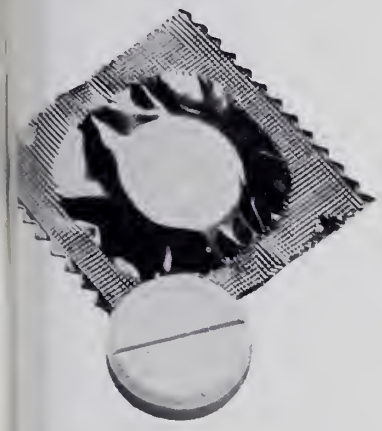


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Pinworm disease	Two doses per day for 1 day. Repeat in 7 days. This regimen is designed to reduce the risk of reinfection.	If this is not practical, give 2 doses per day for 2 successive days.
Threadworm,* large roundworm,* hookworm,* and whipworm* disease	Two doses per day for 2 successive days.	A single dose of 20 mg/lb or 50 mg/kg may be employed as an alternative schedule, but a higher incidence of side effects should be expected.
Creeping eruption	Two doses per day for 2 successive days.	If active lesions are still present 2 days after completion of therapy, a second course is recommended.
Symptoms of trichinosis* during the invasive phase of the disease	Two doses per day for 2 to 4 successive days according to the response of the patient.	The optimal dosage for the treatment of trichinosis has not been established.

*Clinical experience with thiabendazole for treatment of each of these conditions in children weighing less than 30 lb has been limited.



Editorials

Emergencies, Urgencies and Anxious Callers

It's so easy for a well-established, busy doctor to keep such a full appointment schedule that he has no flexibility for handling the very patients who really need him the most, namely, those with real or imagined emergencies and "urgencies."

The only effective way to have time for "work-ins" is to keep an unscheduled 15 minutes every morning and every afternoon. Not many doctors are willing to do this because if no urgency arises, the time—and revenue—is wasted. If a doctor is willing to accept patients with urgent needs on the spur-of-the-moment, but doesn't allot time for them, he ends up throwing his day's schedule behind and causes some unhappiness with his regularly scheduled patients.

In my opinion, we're practicing medicine at its best when we make ourselves promptly available to patients who have a real or imagined need for our services. We all drop everything to assist the person in a life threatening situation, but are we willing to schedule ourselves to be able to see promptly the patient in pain or in distress about some bodily malfunction that seems to him or her to be serious? Is the girl who answers your office phone interested enough to discover the caller's problem or does she say unemotionally, "I'm sorry, but Dr. Jones is booked solid for the next two weeks"? Are you willing to keep your appointment book loose enough to say "come in at 11:30 and we'll have a look at you," or, to let your home phone number appear in the directory so people can call you at any hour, exposing yourself to occasional abuse by selfish individuals? Dedicated doctors must be willing to take these risks and put up with the inconveniences.

It's a nice sound when a patient says, "I'm so glad you would see me so quickly, I was really worried about myself." Isn't this really what the practice of medicine is all about?

Curtis D. Benton Jr., M.D.
Fort Lauderdale

Lunar Reflections

Earthlings who walked on the moon returned with the bends of the soul. Rocketing to the moon, they explored its desolation, seeking answers to the mysteries of the heavens beyond, and returned as changed men. Somehow, in their stay on that timeless, lifeless land they found a new understanding of themselves, their earth and mankind. Returning home the ten men who set foot on the moon have found that previous visions of grandeur, ambition and profit-making were altered by their quarter of a million mile journey through space. Carried so far from home they all developed a new appreciation of everything on earth—changing their view of themselves, their role in life, and their entire philosophy.

Impressed by the awesome size of the universe and the majestic symmetry of the whole of creation, they had difficulty espousing the fact that the earth is only a small globe. They talked about the beauty of the earth and the still, soundless, death-like beauty of the moon. They returned with new understandings and new perceptions, keenly aware of the necessity for all men to work together for peace on this planet in order that it will continue its travel through space.

The trip lifted their sights beyond the confines of day-to-day living of earth creatures who too easily become bitterly parochial, blindly believing that one's own domain is the center of the universe.

On the moon one can take time to look at the entire spacious, starry heavens. Backing away from the earth for such a long look, only then does one realize that ours is a small, insignificant, fragile sphere, yet, an important part of an orderly, gigantic, solar system. C.M.C.

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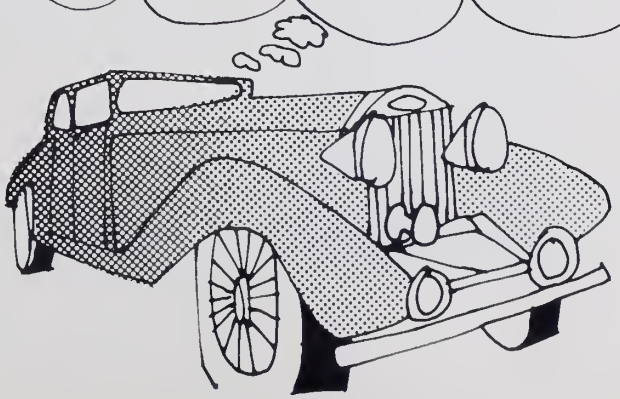
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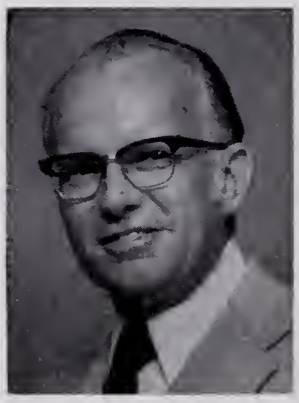


ORGANIZATION

Know Your Board of Governors

In order to acquaint our readers with their Board of Governors, we have badgered our photographer, Bill Elsner and our editorial consultant, Tom Jarvis to obtain a pictorial and literary likeness of each member. The photographs show up their better points, but space has limited our describing their many, many activities and talents. In the event that you get to know them as well as we have, there's no doubt but what you'll agree that they are very capable of guiding the FMA Ship of State.

C. M. C.



William J. Dean, M.D., is the 96th President of the Florida Medical Association and practices internal medicine at St. Petersburg, his home since moving there at age 11 from Atlanta where he was born. He attended local schools but returned to Atlanta and Emory University and Grady Hospital for academic study, internship and residency training. As a major in the Army Medical Corps, Dr. Dean served in Korea and later as chief of cardiology at Fort Carson, Colo. He returned to St. Petersburg in 1954 and subsequently served as secretary and as president of the Pinellas County Medical Society and as Vice President, member of Board of Governors and on numerous committees of FMA. He is a Diplomate of the American Board of Internal Medicine, Fellow of American College of Physicians, member of Florida Society of Internal Medicine and American Society of Internal Medicine. Dr. and Mrs. Dean, formerly Polly Grant of Atlanta, Ga., have two sons and one daughter.



Joseph C. Von Thron, M.D., is a family physician in Cocoa Beach and a charter Diplomate of the American Board of Family Practice. He becomes the 97th President of the Florida Medical Association at the Annual Meeting in May 1973. Born in Orlando, Dr. Von Thron was graduated from the U. S. Merchant Marine Academy and Ohio State University. The latter school conferred the Doctor of Medicine degree upon him in 1954 and he entered the internship program at Jackson Memorial Hospital in Miami. He served as president of the Brevard County Medical Society and has been active in FMA councils and committees for a decade. He is a past president of the Florida Academy of Family Physicians and has been active in Blue Shield of Florida as a member of its Board of Directors and in the University of Florida College of Medicine as a member of the Medical Advisory Committee. Dr. and Mrs. Von Thron, formerly Jane Taylor of Columbus, Ohio, are parents of two sons and two daughters.

Vernon B. Astler, M.D., has practiced general surgery since moving to Florida in 1956. A native of Wyoming, Ohio, he attended Miami University and was graduated from Temple University School of Medicine in Philadelphia; later serving an internship and surgical residency at University Hospital in Ann Arbor, Mich. He was a clinical instructor there before moving to Florida. The University of Michigan Graduate School awarded him the Master of Surgery degree in 1953. He is past president of the Palm Beach County Medical Society, member of the Florida Association of General Surgeons, F. A. Coller Surgical Society, Pan American Medical Association, Southeastern Surgical Congress, Fellow of American College of Surgeons, and a Diplomate of the American Board of Surgery. He is president of the Board of Medical Examiners, State of Florida. Dr. Astler is a member of Sigma Nu Undergraduate Fraternity, Phi Chi Medical Fraternity, Director of the Palm Beach County Chapter of the American Cancer Society and a former Captain in the Army having served in Korea and Japan. Dr. Astler has one son and two daughters. He resides in Delray Beach with his wife, Diane.



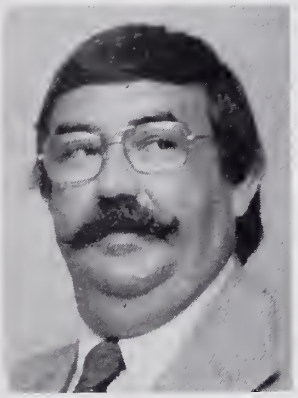
James T. Cook Jr., M.D., of Marianna served as the 94th President of the Florida Medical Association and in 1960 was selected as "General Practitioner of the Year" by the American Medical Association. He has been practicing in Marianna since 1945. That year he was released from the Army Medical Corps with the rank of captain. Dr. Cook was born in Porterdale, Ga., and educated at Emory University and its School of Medicine. He served an internship at Emory University Hospital. For more than a decade he has been active in the Florida Academy of Family Physicians, serving as president and chairman of the Board, and the American Academy of Family Physicians, principally on its Commission on Hospitals. He served FMA as Vice Speaker and Speaker of the House of Delegates and as a member of numerous committees, also as the Jackson-Calhoun County Medical Society president for two terms. He and Mrs. Cook, formerly Lillian Schwencke of Thomasville, Ga., are parents of one son and three daughters.



James F. Cooney, M.D., has practiced neurosurgery at West Palm Beach since 1954, the year he completed a residency at the Mayo Clinic and obtained a license to practice in Florida. He served an internship at the St. Albans Naval Hospital in New York. A native of Milford, Mass., Dr. Cooney was graduated from the University of Notre Dame and the Yale University School of Medicine. He is a past president of the Palm Beach County Medical Society and of the Florida Neurosurgical Society and has been active in various committees and councils of the Florida Medical Association. Dr. and Mrs. Cooney, formerly Rosemary Kuhn of Decorah, Iowa, have six sons and two daughters.



Richard C. Dever, M.D., completed a surgical residency at Jackson Memorial Hospital in Miami in 1958 and has been practicing this specialty there since that time. Before coming to Jackson he had served an internship and a residency in surgery at Johns Hopkins Hospital in Baltimore. He was Harvey Cushing Fellow in Surgery. A native of Jackson, Miss., he attended Marion Institute at Marion, Ala., and was graduated from Millsaps College at Jackson. Johns Hopkins University School of Medicine conferred the Doctor of Medicine degree upon him in 1952. Dr. Dever has been active in the Dade County Medical Association and in the scientific educational activities of the Florida Medical Association. He is a member of the Florida Association of General Surgeons, American College of Surgeons, and of the American Board of Surgery. Dr. and Mrs. Dever, formerly Joan Burlingame of Little Rock, Arkansas, have three daughters.



Burns A. Dobbins Jr., M.D., practices pediatrics in Fort Lauderdale and is one of the Florida Medical Association's delegates to the American Medical Association. A native of Birmingham, Ala., he is a graduate of the University of Florida and Temple University School of Medicine in Philadelphia. He served an internship at Philadelphia General Hospital and a residency at Columbia Presbyterian Hospital. Dr. Dobbins entered practice at Sweetwater, Tenn., in 1941 but after one year became a medical officer in the U. S. Navy and was discharged as a lieutenant commander four years later. Shortly thereafter he entered practice

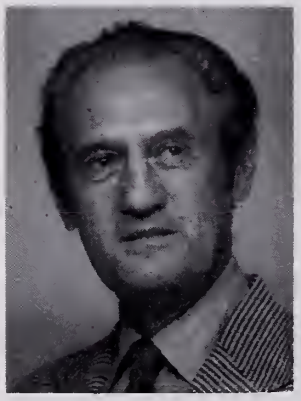


in Fort Lauderdale. He is a past president of the Broward County Medical Association and of the Florida Pediatric Society and, additionally, a member of the Florida Academy of Family Physicians, American Academy of Family Physicians and Southern Medical Association. He served nine years on the Council on Medical Services and is presently on the Judicial Council of the American Medical Association. Dr. and Mrs. Dobbins, formerly Estelle Guthrie of Sweetwater, Tenn., have two sons.

Irving M. Essrig, M.D., is a native of Tampa and has been practicing surgery there for two decades. He attended the University of Florida and graduated from Tulane University School of Medicine and served an internship and residency at Touro infirmary. During this time he engaged in the postgraduate study of physiology at Tulane University. In 1948 Dr. Essrig joined the faculty of Louisiana State University School of Medicine as Instructor of Surgery and two years later became Assistant Professor of Surgery. He is a member of the Medical Advisory Committee at the University of South Florida College of Medicine and Consultant in Surgery to the V.A. Hospital, Bay Pines and the new Tampa V.A. Hospital. He is Director of the Department of Surgery at St. Joseph's Hospital, Tampa. A former Wing Surgeon with the 9th Air Force, Dr. Essrig is immediate past president of the Hillsborough County Medical Association and a member of the Southeastern Surgical Congress and the American College of Surgeons. He and Mrs. Essrig, formerly Louise Karp of New Orleans, have three sons and one daughter.



Franklin J. Evans, M.D., Speaker of the Florida Medical Association's House of Delegates, has conducted a general and family practice in Coral Gables for 24 years. He began practice in Miami in 1946 following service as an Army Medical Officer. A native of New York City, Dr. Evans was graduated from City College of New York and the School of Law and College of Medicine of New York University. He interned at Kings County Hospital in Brooklyn and continued postgraduate studies at the Cook County Graduate School of Medicine. He is Associate Professor of Legal Medicine at the University of Miami School of Medicine and Special Assistant State Attorney and Medico-Legal Advisor, State Attorney's Office, Dade County. Dr. Evans is a past president of the Dade County Medical Association and of the Florida Academy of Family Physicians. He is a Fellow of the American Academy of Forensic Sciences and Vice President of the American Medico-Legal Society. Dr. and Mrs. Evans, formerly Joan Hollingsworth of Fayette, Ala., have one daughter.

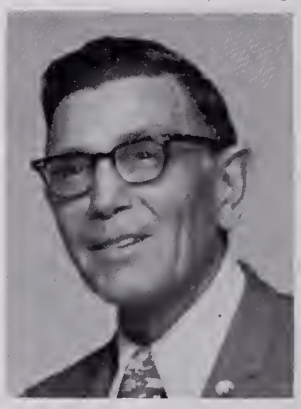


John C. Fletcher, M.D., Florida Medical Association's Vice President, is a native Floridian and has been practicing general surgery at Tampa for 15 years. He



was born at Greensboro, served in the Navy, graduated from the University of Florida and Emory University School of Medicine and subsequently completed an internship and a residency at Barnes Hospital in St. Louis. At that time Dr. Fletcher served as a member of the Department of Surgery faculty at the Washington University School of Medicine. He also has been a visiting faculty member at the University of Florida College of Medicine. He is chairman of the Board of Censors, Hillsborough County Medical Association; district counselor, American College of Surgeons, and a member of the Southern Medical Association and Southeastern Surgical Society. Dr. and Mrs. Fletcher, formerly Doris Corine Stewart of Kosciusko, Miss., have a son and two daughters.

Floyd K. Hurt, M.D., a practicing radiologist in Jacksonville since 1941, was the Florida Medical Association's 95th President, serving a 1971-1972 term following eight years as Secretary-Treasurer. A Virginian, he received premedical education at Emory and Henry College and earned the M.D. degree in 1935 at the University of Virginia School of Medicine. Following an internship at Duval Medical Center in Jacksonville, Dr. Hurt became an assistant instructor in pathology at the University of Virginia School of Medicine; then served a radiology residency at Duke University Hospital. A former major in the Air Force, he is past president of the Florida Radiological Society and Duval County Medical Society, a Fellow of the American College of Radiology, served seven years as secretary-treasurer of FMA, and active in the committees and councils of FMA. Dr. and Mrs. Hurt, formerly Veronna Griffin of Blountstown, have two daughters.



Jack A. MaCris, M.D., whose special medical interest is general and vascular surgery, has been practicing at St. Petersburg since completing a residency at University Hospital at Ann Arbor, Mich., the latter part of 1955. A native of Michigan, he was graduated from Michigan State University and the University of Michigan Medical School, and earned the Master of Science in Surgery degree from the Horace Rackham School of Graduate Studies at Ann Arbor. A former line officer in the Navy, Dr. MaCris is a past president of the Pinellas County Medical Society; president, American College of Surgeons, Florida Chapter,



and past president of the Florida Association of General Surgeons, and past councilor of the Frederick A. Coller Surgical Society. He has served as a director of the St. Petersburg Area Chamber of Commerce and Kiwanis Club. Dr. and Mrs. MaCris, formerly Janet McFarlane of Detroit, have two daughters and one son.

Eugene G. Peek, Jr., M.D., is a native of Ocala and has been practicing general medicine and surgery there since 1948. He attended Stetson University, University of Florida and University of Richmond and was granted the Doctor of Medicine degree by the Medical College of Virginia. He interned at its Hospital and served a surgical residency at St. Elizabeth's Hospital in Richmond. Dr. Peek is a past president of the Marion County Medical Society and has served the Florida Medical Association as Vice Speaker and Speaker of the House of Delegates, as Vice President and as a member of numerous committees. He is chairman of the Advisory Committee for the Florida Division of Health, member of the Florida Academy of Family Practice, American Academy of Family Practice, and Southern Medical Association, Fellow of Southeastern Surgical Congress, and an alternate delegate to the American Medical Association. In May 1969, he was awarded the FMA highest award—the Certificate of Merit. In February 1972, he received the State of Florida Merit Award and in September 1972, he was awarded the Meritorious Service Award by the Florida Public Health Association. Dr. and Mrs. Peek, formerly Virginia Bugg of Grove Hill, N. C., have four sons.



James W. Walker, M.D., practices pediatrics in Jacksonville and is Secretary-Treasurer of the Florida Medical Association. A native of Cookeville Tenn., he attended Vanderbilt University and the University of Tennessee College of Medicine conferred the Doctor of Medicine degree upon him in 1953. Later that year he began an internship at the Duval Medical Center in Jacksonville and became a resident physician there one year later. He also served as a resident at Charity Hospital in New Orleans. In addition to FMA and AMA, Dr. Walker is a member of the Southern Medical Association, Florida Pediatric Society, American Academy of Pediatrics and the Southern Society of Pediatric Research. He is past president of the Duval County Medical Society. He served in the Navy during World War II. He and Mrs. Walker, formerly Mary Louise Bartlum of Orlando, have two sons.



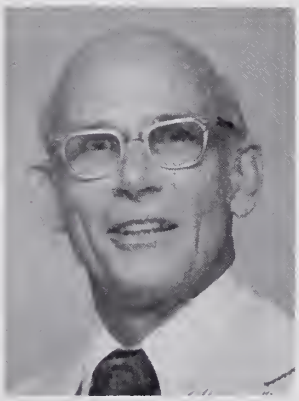
W. M. C. (Merrill) Wilhoit, M.D., has practiced psychiatry and neurology in Pensacola since 1952. Born in Quincy, the son of a general practitioner, he is a graduate of the University of Florida and the Duke University School of Medicine. He completed psychiatric residencies at Duke and at St. Elizabeth's Hospital and neurological training at Duke and Illinois Neuropsychiatric Institute. He served as a Naval Reserve Medical officer in the Pacific.



He is past president of the Escambia County Medical Society and was Chief of Staff of the University Hospital. In the field of mental health, he has been chairman of the Council on Training and Research, the Advisory Council, and AMA Committee on Mental Health. He is a past president of the Florida Association of Mental Health.

A fellow of the American and Southern Psychiatric Associations, he is currently President of the Gulf Coast Society of Psychiatry and Neurology. He is Head, Department of Neuropsychiatry and past president of the Medical Center Clinic partnership and currently President of the Medical Center Clinic Corporation. A former member of the University of Florida golf team, he is a member of the Pensacola Country Club and member and past president of Scenic Hills Country Club. Married to the former Martha Watkins of North Carolina, Dr. and Mrs. Wilhoit have a son, five daughters and one granddaughter.

Robert E. Zellner, M.D., served as the Florida Medical Association's 82nd President in 1962 and since 1966 has been a delegate to the American Medical Association. A native of Lakeland, he has practiced general surgery in Orlando since World War II in which he served as a Naval Medical Officer. Dr. Zellner is past president of the Orange County Medical Society and has been active on many FMA committees principally those concerned with insurance, fee schedules and medical economics. He was elected to the Blue Shield Board of Directors in 1965 and he has served as its Chairman since 1971. Educated at the University of Florida, Rush Medical College and the University of Chicago, he interned at Grady Hospital in Atlanta and served a residency at Orange Memorial Hospital in Orlando. Dr. Zellner is a member and Past President of the Florida Association of General Surgeons, and a fellow of the American College of Surgeons. He and Mrs. Zellner, formerly Jean Brown of Lakeland, have two daughters and one son.



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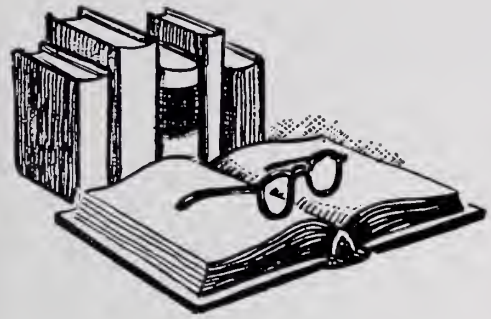
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Book Reviews

Lasers in Medicine by Leon Goldman, M.D. and R. James Rockwell Jr. Pp. 385. Illustrated. New York, Gordon and Breach, Science Publishers, Inc., 1971.

If one is looking for an erudite and authoritative review of the history, development, and application of lasers in medical science, this compendium by two staff members of the Laser Laboratory of the Medical Center of the University of Cincinnati should end the quest. Written jointly by a physician and a physicist, the book covers in satisfying detail the physical principles, developmental research, and medical indications for this exciting therapeutic tool. Extensive bibliographies follow each chapter.

Most of the book, however, might intrigue the biomedical physicist or engineer more than the clinician since considerable space is afforded to formulae, optical diagrams, and explanations of physical phenomena. Those chapters devoted to medical application of lasers in ophthalmology, dermatology, and neoplasia are clinically astute.

Each chapter is generously supplemented with appropriate diagrams, photographs, and tables. Chapters are also subdivided and paragraphs numbered for convenient use as a reference text. The reliable clinician must look ahead in medicine, and this book gives him a generous peek.

HARRY W. EICHENBAUM, M.D.
ST. PETERSBURG

A Primer of Electrocardiography by George E. Burch, M.D. and Travis Winsor, M.D. Pp. 292. 287 Illustrations. Price $7.75. Philadelphia, Lea & Febiger, 1972.

Since—in the past decades—the EKG has become the ECG and has migrated from the cardiologist's office to that of the general practitioner or, as he is now known, the generalist, there have been a rash of "Primers" on the principles, the taking, and the interpretation of the ECG. Each author, in one way or another, assures the reader that *HIS* is truly a primer and will make interpreting the tracing no more difficult than reading the daily newspaper.

A Primer of Electrocardiography has passed through six editions and 38 printings and has been translated into Czech, French, Greek, Italian, Japanese, Spanish, and Serbo-Croat. One thinks, a book with a publishing history like that can't be *ALL* bad.

I notice that the printings are growing fewer from the First Edition (1945—10 printings and 3 translations) to the Fifth Edition (1966—3 printings and no translations). This, probably, is a sign of competition from other authors.

In any event, my loving wife bought me as a birthday gift the Fourth Edition back in 1960. After thumbing through it a whole evening, I rejected it as too dry and went out and got another "Primer" for myself. With apologies to Mr. Lea and Mr. Febiger, the present volume does not appear to be too different from the one I received twelve years ago. It really isn't. As Drs. Burch and Winsor put it in the preface "—and realizing the purpose for which this book was first written, the sixth edition was changed very little. It was considered inadvisable to change this monograph merely for the sake of change"; however, to get to the heart of the matter (no pun intended), this lean volume is pointed at the medical student, the intern, the resident, and any beginner in the field of electrocardiography. It is divided into five chapters and covers everything fairly well the electrocardiologist must know.

All necessary facts and material are offered, but so far as I am concerned, the presentation is on the dull side and a little too text-bookish in this day of programmed instruction. Perhaps, I have been spoiled by Dr. Netter's superb plates in the Oct-Nov-Dec 1968 issue of Ciba's CLINICAL SYMPOSIA.

ARTHUR F. SCHIFF, M.D.
MIAMI

Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

Cardiovascular Physiology, Second Edition, by Robert M. Berne, M.D. and Matthew N. Levy, M.D. Pp 265. 193 Illustrations. Price $9.25. St. Louis, The C. V. Mosby Company, 1972.

The Truth About Vitamin E by Martin Ebon. Pp. 154. Price $1.25. New York, Bantam Books, Inc., 1972.

Hematopoietic and Gastrointestinal Investigations with Radionuclides by Albert J. Gilson, M.D., William M. Smoak III, M.D. and Morton B. Weinstein, M.D. Pp. 456. Illustrated. Price $30. Springfield, Ill., Charles C. Thomas, Publisher, 1972.

Synopsis of Pathology, Eighth Edition by W. A. D. Anderson, M.D. and Thomas M. Scotti, M.D. Pp. 1076. 433 Illustrations. Price $13.95. St. Louis, The C. V. Mosby Company, 1972.

A Civilian Doctor in Vietnam by Fred Gloeckner, M.D. Pp. 123. 27 Illustrations. Price $5. Philadelphia, Pa., The Winchell Company, 1972.

Review of Medical Microbiology by Ernest Jawetz, M.D., Ph.D.; Joseph L. Melnick, Ph.D.; Edward A. Adelberg, Ph.D. Pp. 518. Illustrated. Price $8.00. Los Altos, Calif., Lange Medical Publications, 1972.

Mental Health Training and Public Health Manpower by Stephen E. Goldston, Ed. D., M.S.P.H. and Elena Padilla, Ph.D. Pp. 294. Price $2.75. Rockville, Maryland, National Institute of Mental Health, 1971.

Review of Medical Pharmacology, Third Edition by Frederick H. Meyers, M.D., Ernest Jawets, M.D. and Alan Goldfien, M.D. Illustrated by Laurel V. Schaubert. Pp. 688. Price $8.50. Los Altos, Calif., Lange Medical Publications, 1972.

Malnutrition, Its Causation and Control, Volume I and II by John R. K. Robson. Pp. 613. Illustrated. New York, Gordon and Breach, Science Publishers, Inc., 1972.

Current Pediatric Diagnosis Treatment, 2nd Edition, by C. Henry Kempe, M.D., Henry K. Silver, M.D. and Donough O'Brien, M.D. Pp. 1008. Illustrated. Price $12.00. Los Altos, California, Lange Medical Publications, 1972.

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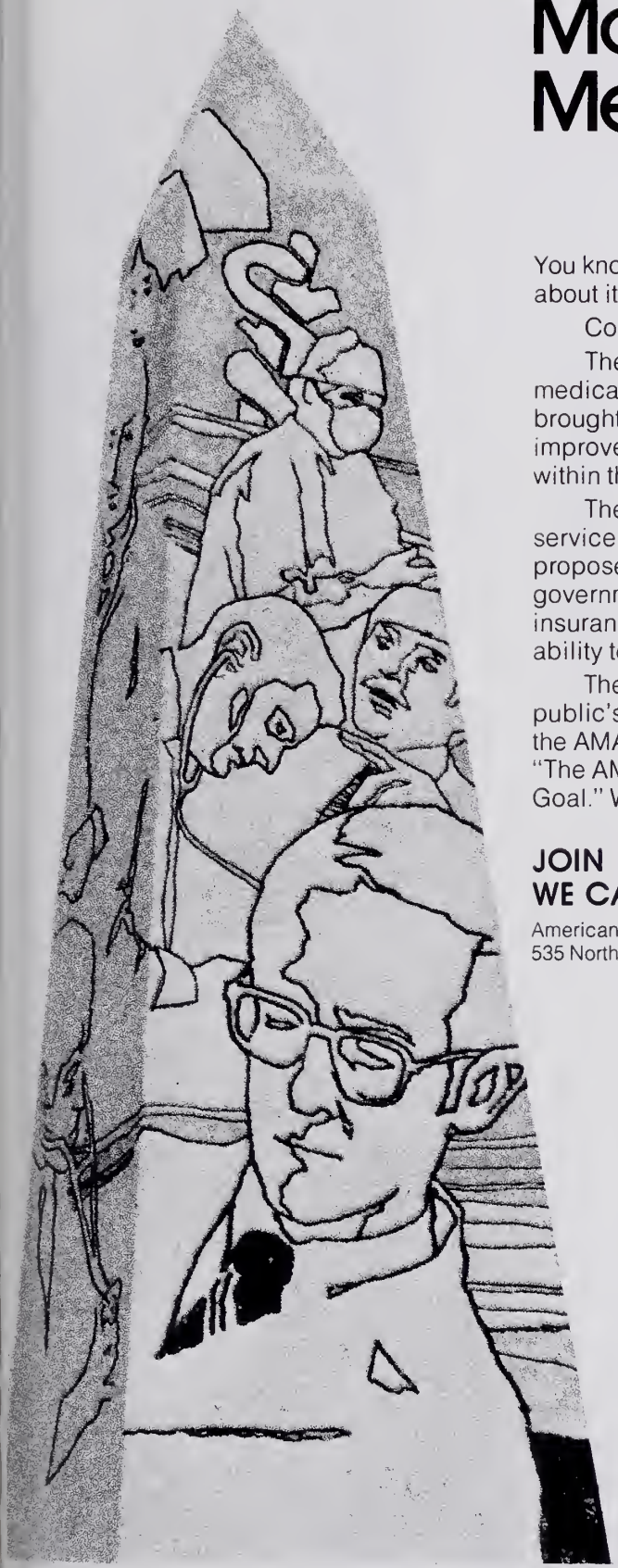


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Annual Meeting

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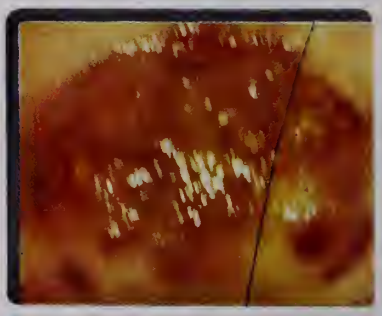
The AMA has vigorously opposed a government controlled medical system. And our testimony before Congress has brought results. Today key legislators acknowledge that improvement of health care can be best accomplished within the framework of our present system.

The AMA is acutely aware that more and better health service must be delivered to the public. To do it, the AMA has proposed a number of programs. One is Medicredit, a government supported program of voluntary national health insurance. It would insure every American—regardless of his ability to pay—of obtaining quality medical care.

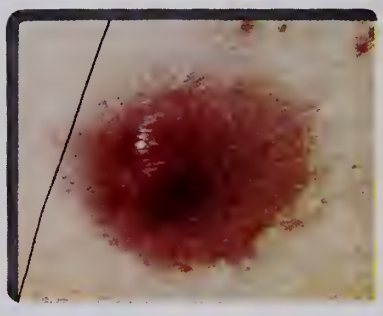
The AMA is working hard to protect your interests and the public's. But we need your support. Find out more about what the AMA is doing for you and the public. Send for the pamphlet, "The AMA and the American Doctor: Sharing a Common Goal." Write: Dept. DW, at the address below.

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The Physician-Patient Relationship
A New Approach To Informed Consent

By Lawrence V. Hastings, M.D., LL.B.

Although the "lack of informed consent" medical malpractice action is of relatively recent origin, the number of lawsuits based on this theory of liability is increasing at an incredibly rapid rate. How can the physician or surgeon best protect himself against such an action or an unfavorable verdict? There are standard methods for avoiding informed-consent-litigation and, in my opinion, a "new approach" which merits earnest consideration.

Some of the wellknown and accepted ways to avoid liability may be summarized briefly. *First and foremost,* the doctor can ascertain the amount of information normally or usually given by other doctors under similar circumstances and conduct himself accordingly in obtaining the necessary consent. Whether the malpractice action is grounded in negligence (tort) or breach of contract, the controlling question concerning an informed consent is whether or not the doctor adhered to "the standard prevailing in the community, i.e., accepted practice" among physicians, surgeons, or specialists of the doctor's professional standing in advising the patient of the specific risks, etc., involved in the particular medico-surgical procedure contemplated.* *Second,* the doctor can secure a signed consent form including not only the name of the procedure involved but also a summary of the information given prior to the signing. *Third,* the doctor can record his reasons for "therapeutic nondisclosure" if and when in his professional judgment the withholding of certain information is advisable (for example, if he deems the patient too sick to receive such knowledge or if he feels fear and apprehension will increase the operative risk). *Fourth,* the doctor can share the responsibility he bears by informing the patient and securing the requisite consent in the presence of one or more doctors who concur in the degree of information given or withheld.

I would like to suggest a "new" approach to avoiding malpractice suits based on lack of informed consent, namely, giving the *average* patient *more* information than has been deemed necessary and proper by the medical profession in the past. This approach is novel not because it has never been used but rather because it has never been used much. The simple fact of the matter is that "doctor always knows best" and "a good doctor knows all but tells nothing" are platitudes reflecting attitudes obviously obsolete. They have outlived their usefulness, in my opinion, and just as we hope that "Cessante ratione legis, cessat et ipsa lex" (when the reason for a law ceases the law itself also ceases), so when a traditional aspect of the doctor-patient relationship is no longer valid, it too should disappear.

I suggest that the "silent doctor" is outdated or soon will be for many reasons, some of which follow. Television and other mass media have made the average American a walking encyclopedia of medical information (and/or *mis*information). Moreover, the "do-it-yourself" philosophy which has permeated our country in areas ranging from house repairs to flying has invaded the health field too. Nor can we ignore the fact that many "under 30s" feel their life-choices are severely limited by "The Establishment," "the system," etc., and insist upon as much awareness as possible of "what choices are left." Lastly, there seems to be an ever-increasing desire for deeper interpersonal relationships in today's world (correlative perhaps to the equally-increasing feelings of alienation), a desire crossing all boundaries of age, sex, skin color, religion and national origin; certainly the doctor/patient relationship is (or should be) a significant one in a person's life.

In conclusion, the doctor who feels freer to give his average patient more information concerning a proposed medical or surgical procedure is giving himself good protection against an accusation of failure to get an informed consent. It is true that the "old ways" of avoiding such a malpractice suit remain important. It is also true that some patients want to "leave everything up to the doctor" and that some patients necessitate therapeutic nondisclosure. Nevertheless, a new approach should prove valuable with many patients, valuable not only in preventing litigation but also in improving the doctor/patient relationship.

*See e.g., *Dittow v. Kaplan,* Fla. App. 1965. 181 So 2d. 226,228. The above-stated *general* rule is subject to modification in various jurisdictions and should not be relied upon blindly.

Reprinted from the Dade County Medical Association Bulletin, March 1972.

With the means at hand to drastically reduce the number of deaths each year from uterine cancer, we have embarked on a nationwide, life-saving program. Its goal is a Pap test by 1976 for every woman 20 years or older to whom the test is applicable, and for younger women at risk. An ambitious program, doctor, and one which can only be realized with your help.

We are faced with these facts: only 53% of women over 20 have ever had a Pap test; only 20% get a Pap test periodically; each year about 43,000 new cases are diagnosed; this year 12,000 women in this country will die of uterine cancer. And about 75% of these deaths will result from cervical cancer—as you know, almost 100% curable when diagnosed early and treated promptly.

We hope to reach women in the target group not only with the message about the *vital* Pap test, but also with the urgency of including it in the *regular* health checkup. The mortality rate from uterine cancer could thus be dramatically curtailed.

Clearly action is called for. Coordinated action—involving the doctor, the patient, the American Cancer Society—a partnership for life.

a partnership for life



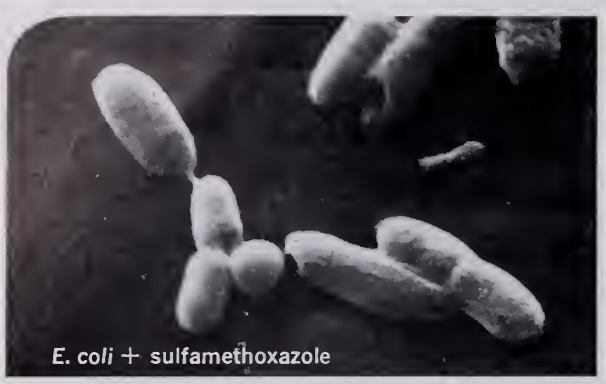
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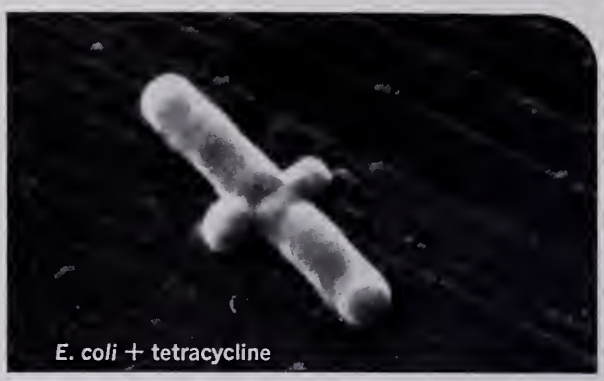
Encounter under the Scanning Electron Microscope



SEM reveals changes in *E. coli* exposed to antibacterial agents

The Scanning Electron Microscope (SEM) is the only instrument which gives 3-dimensional views on a microscopic level. This permits the surface morphology of microorganisms to be observed in detailed perspective. Changes in surface morphology of *E. coli* exposed to various antimicrobial agents are seen on the following page. An SEM photomicrograph of normal control *E. coli* appears above.









Different modes of antibacterial action — Similar changes in morphology

As part of a series of experiments,[1-3] strains of *E. coli* proven susceptible to each antibacterial agent were exposed to 1 MIC of the respective antibacterials for a three-hour period. Included were cell-wall-active drugs, ampicillin and cephalothin; a drug interfering with intracellular protein synthesis, tetracycline; and a chemical agent which acts by interference with para-aminobenzoic acid, sulfamethoxazole.

As seen above, elongation of the bacilli, mid-cell defects and spheroplast-like forms may be appreciated with the SEM technique. These changes in bacterial morphology were similar... regardless of the antibacterial agent used and irrespective of its mechanism of action.

"At present, the significance of these observations in clinical infection must be considered with caution, but it is hoped that these data will stimulate a reevaluation of present concepts of the nature and role of morphological variants of bacteria exposed to a variety of antibacterial factors."[2]

It should be noted that no clinical conclusions can be drawn from this study, as it is not always possible to extrapolate *in vitro* data to humans.

References: 1. Klainer, A. S.; Fass, R. J., and Perkins, R. L.: Scientific Exhibit presented at the 25th American Medical Association Clinical Convention, New Orleans, La., Nov. 28-Dec. 1, 1971. **2.** Klainer, A. S., and Perkins, R. L.: *Antimicrob. Agents Chemother., 1*:164, 1972. **3.** Klainer, A. S.: Data on file, Hoffmann-La Roche Inc., Nutley, N.J.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis,

Encounter in Clinical Practice

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Subsequent 1-Gm doses provide up to 12 hours of antibacterial coverage. More severe u.t.i. may require a q. 8 h. dosage regimen. Either schedule provides coverage during the waking and sleeping hours—especially important during hours of sleep when normal urinary retention tends to favor bacterial proliferation.

Also effective in nonobstructed chronic and recurrent u.t.i.

It is not uncommon for the elderly and the debilitated to develop chronic and/or recurrent nonobstructed urinary tract infections such as pyelonephritis and cystitis. Such cases often respond satisfactorily to Gantanol. The increasing frequency of resistant organisms is a limitation of usefulness of antibacterial agents including sulfonamides, especially in chronic or recurrent u.t.i.

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Either dosage form—the Tablets or the pleasant-tasting, cherry-flavored Suspension—can provide the dependable antibacterial activity necessary to control susceptible nonobstructed cystitis and pyelonephritis. Symptomatic improvement may usually be expected in 24 to 48 hours. The usual precautions with sulfonamide therapy should be observed, including adequate fluid intake. Gantanol (sulfamethoxazole) is generally well tolerated with relative freedom from complications; the most common side effects are nausea, vomiting and diarrhea. Frequent c.b.c.'s and urinalyses with microscopic examination are recommended.

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aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

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A Rendezvous at Chickamauga

I. Barnett Harrison, M.D.

Secession was the popular outcry. My great grandfather stumped Alabama and Georgia in opposition; his views did not prevail. Several years later, as a Confederate Colonel, he was killed in the Battle of Chickamauga.

Blue Shield was once a relatively simple and isolated private nonprofit insurance organization designed to help people with medical expenses. It later became involved with government programs, including the mammoth Medicare plan. The organization is now besieged, receiving volleys from the government, the people, the press, and the doctors. Some say the tail now wags the dog. Thus, life has become more complicated. The role of a Blue Shield board member is challenging and frustrating. Problems are not only difficult to solve; they are difficult to understand.

Again, we hear talk about secession: Secession of Blue Shield from the ill-fated union with the Federal Government; Secession of Florida Medical Association from Blue Shield; Secession of individual participating physicians from Blue Shield. And in Washington city, a prominent Massachusetts Senator tells us that his solution to the problem would lead to abolition of health insurance organizations, including the "Blues."

The road of reason must lie somewhere between these extreme points of view, but this pathway will not be a smooth one to travel. Much hard work awaits those who are willing to confront national and local health crises in a problem-solving mood. In the words of John Gardner, "Accomplishing social change is a task for the tough-minded and competent."

The easy, but short-sighted approach is to secede. As a member of the board, I believe that Blue Shield should stay in the union, and continue to struggle with the problems that face us. As a practicing physician, I think the physicians of Florida should participate in Blue Shield, and put forth every effort to make it work. Individually and collectively, we need to participate, communicate, negotiate in all realms at all levels if we are to help shape our future.

I have no desire for a rendezvous at Chickamauga.

▶ Dr. Harrison, 1433 Miccosukee Road, Tallahassee 32303.

The Committee of Seventeen

Within a decade after its humble origin some 25 years ago, Blue Shield of Florida became a very viable and complex organization. As it extended, through the experience of need, its scope of benefits and the type of contracts offered, both outgrowths of consumer and physician demands, many new problems arose. Some 15 years ago, therefore, the Florida Medical Association formed a Committee of Seventeen of its physicians whose very title signifies its purpose, Committee on Advisory to Blue Shield.

Physicians are appointed to this Committee from each of the medical districts within the state and care has always been exercised to see that most of the diverse specialties are represented. Such a choice, therefore, permits expression of grassroot opinion throughout the length and breadth of the state as well as within the various fields of medical practice. As physicians are so intimately involved in the needs of the patients they serve, the patient is thus also represented through the voice of his doctor in Committee deliberations.

In the early days of the Committee of Seventeen, much more effort was expended in the development of various contracts. As these became firmly established, the work largely changed to solving the dilemmas and the problems created by these contracts. Much effort was expended in the improvement of already existing contracts. It is true that the earlier Blue Shield contracts were more surgery-oriented. The Committee, therefore, spent much time and effort in widening the scope of benefits to include the various other specialties. As Blue Shield became recognized for the efficiency of its operation, the federal government requested that it act as Fiscal Intermediary for such programs as CHAMPUS, and ultimately MEDICARE. Blue Shield accepted these government proposals because they increased the scope of operations, improved to some degree the financial position, and assisted in providing medical care and its payment for those Florida citizens who were Blue Shield subscribers, dependents of military personnel, or persons over age 65. At no time, however, did Blue Shield become involved unilaterally with government programs. At no time did its officials enter into participation with the government in providing medical care, be it to the federal employees, military personnel, or senior citizen without the advice, consent, and request of the Florida Medical Association. This fact, I think, is often lost sight of by the doctors in Florida.

As Blue Shield did become involved with the government in the providing of health care payments, new problems were created for the doctors in the state. Again the character of the Committee of Seventeen changed. It now has become involved in advising Blue Shield in its capacity as Fiscal Intermediary for these various government programs. This increased activity was reflected in the change of its title to the Florida Medical Association's Committee on Advisory to Blue Shield and Fiscal Intermediaries.

The Committee of Seventeen, as presently constructed, met five times this past year. It might be helpful to our fellow physicians to know somewhat the character of these meetings. At a typical meeting are present various members of the Committee, representatives of the Blue Shield staff, and representatives from Florida Medical Association headquarters staff. Officers from the Association are often present. One or more physicians from the Blue Shield Board of Directors often appear as well as guests. These guests may be fellow physicians seeking the Committee's help in the adjudication of varied disputes with Blue Shield or physicians seeking some innovation in health care benefits. During the past year, for example, Mr. Bill Ryan, Vice President of Marketing for the National Association of Blue Shield Plans, was a guest speaker who discussed Blue Shield on the national level. On the agenda has appeared every conceivable complaint against Blue Shield from individual physicians, from county societies and the Florida Medical Association itself. Discussions are most lively and forthright and recommendations to both the Florida Medical Association and Blue Shield are finally made only after due deliberation of all available facts and opinions.

We earnestly try to be temperate and judicious, keeping always in mind the greatest good of the greatest number of physicians, as we cast a vote upon an issue. When our collective judgement goes contrary to the opinion of some physician or group of physicians, the Committee is labeled with the invective, "rubberstamp for Blue Shield." Such a complaint is manifestly unfair to a well-intentioned group of your fellow physicians. As Shakespeare said, "but ye gods would give us

faults to make us men." Despite our best efforts, the Committee knows and will be the first to admit that it is not infallible. Resort can always be sought "up the line" of the parent organization through the various well-known democratic approaches. It must also be remembered by our fellow physicians that our Committee is purely advisory—a sounding board of opinions—a think-tank if you will. We can only recommend to FMA and/or Blue Shield certain actions. With the benefits of our deliberations before them, they, in turn, must, in their best judgement, decide the course of action to pursue. Thus, there are checks and balances.

The Chairman of the Committee and four members are invited to attend each Blue Shield Board of Directors meeting. Prior to the Board meeting, the members present from the Committee meet with the Professional Relations Committee of the Board to discuss further matters that may have been sent directly to Blue Shield from the FMA Board of Governors or recently made suggestions from the Committee of Seventeen. The actions of this meeting are then presented at the Board of Directors meeting. Recall, if you will, that over 50% of the members of the Board of Directors of Blue Shield are fellow practicing physicians elected to these positions by you at the annual FMA meeting. Regardless of whether those physicians who objected a year ago to Blue Shield's use of the term "doctor's own Plan" were right or wrong, what other insurance program in the nation has such a physician involvement in its operation? If for whatever reason it should not publicly receive that accolade, let each of us privately acknowledge that there is more than ample justification for the eponym.

If we have arrived at a time in history when physicians must speak of forming unions for collective bargaining with an ever increasing edacious federal government, as they did at the recently completed annual meeting in May, could we not find the answer we seek in a strong economic union of physicians with Blue Shield on a regional level and through the National Association of Blue Shield Plans on a national level? The individual doctor acting in his own behalf is "the voice of one crying in the wilderness." Fee schedule committees, representing the various special medical organizations, working through a master negotiating committee with and through local and National Blue Shield Plans could provide a unity of purpose and the powerful thrust of a highly sophisticated and computerized amalgam of health care providers to which the social planners must give heed. The mechanism is already in existence. This is the time to strengthen what we have, not a time to dilute our strength by dispersing our efforts into an ever-expanding list of organizations whose purpose is the same.

It should by now be abundantly clear that the Committee of Seventeen is a Committee of the Florida Medical Association not a committee of Blue Shield. For those 17 physicians* to function effectively, they need the help and cooperation of all the doctors in Florida. For the Committee to function in your behalf, we must hear from you individually or in groups the things that concern you greatly about Blue Shield in whatever its function. If we fail to receive your constructive criticisms and suggestions then we have failed to achieve the very purpose of our existence; namely, liaison between you and Blue Shield. The Committee members are and should be representative of opinion in the areas in which each resides. Learn, therefore, who the member is in your district so that you can direct your criticisms and suggestions to him. If he cannot answer your query, he will see that it gets before the Committee for general discussion and ultimate action. Therefore, always keep before you the words of Horace, "Vis unita fortior" "power is strengthened by union."

Raymond J. Fitzpatrick, M.D., Chairman
Committee on Advisory to Blue Shield
and Fiscal Intermediaries
Gainesville

*Other members of the Committee of Seventeen are:

Hoke H. Shirley Jr., M.D. *Naples*
John A. Rush Jr., M.D. *Jacksonville*
William N. Ainsworth III, M.D. *Jacksonville*
Alfred L. Lewis, M.D. *Tallahassee*
William H. Keeler III, M.D. *St. Petersburg*
Ralph C. Aye, M.D. *Tampa*
John C. Fletcher, M.D. *Tampa*
Henry G. Morton, M.D. *Sarasota*
Thomas D. Weaver, M.D. *Clermont*
Jack T. Bechtel, M.D. *Indialantic*
James F. Richards, M.D. *Orlando*
Thomas F. Raymond, M.D. *West Palm Beach*
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Medical News

Dr. Brennan Heads Allergists

Robert J. Brennan, M.D., of Fort Lauderdale, is the new President Elect of the American Association for Clinical Immunology and Allergy.

Dr. Brennan, a member of the Broward County Medical Association and the Florida Medical Association, was chosen at the organization's meeting in Seattle, Wash., in July.

Dr. Guy Joins RMP Staff

Clifford R. Guy, M.D., has been appointed Florida Regional Medical Program District Director for the Jacksonville area, which includes the counties of Duval, Nassau, Baker, Columbia, Union, Bradford, Clay, St. Johns, Flagler, Putnam, Marion, Alachua, Levy and Gilchrist.

One of Dr. Guy's primary assignments will be the development of the Emergency Medical Services Program undertaken by FRMP and the Florida Division of Health. He also will be concerned with health manpower development and training activities of the Program including continuing medical education.

PA Program at Gainesville Receives Grant

The U.S. Department of Health, Education and Welfare has announced a $129,000 grant to help launch the physician's assistant training program at the University of Florida.

Directed by Richard A. Henry, M.D., Assistant Professor of Medicine at Florida, the program will be a joint effort of the Division of Health Related Programs at Santa Fe Community College and the Department of Community Health and Family Medicine at Florida's College of Medicine. More than 1,500 individuals have inquired about the program, and 15 will be selected to begin training with the first class.

A certificate will be given by the College of Medicine after the student completes clinical experience at Shands Teaching Hospital and the Gainesville Veterans Administration Hospital. In its initial phase, the program will prepare assistants to work only with specialists in internal medicine.

The University of Florida Program has been approved by the Florida State Medical Examiners, which is charged with responsibility for administering the Physician's Assistant Act of 1971.

Florida's Bureau of Comprehensive Health Planning reported that of 12,000 physicians responding in a survey, more than 35 per cent indicated they would employ a physician's assistant if one were available.

State Physician Gets Georgia Post

Malcolm N. Luxenberg, M.D., who has been engaged in private practice at West Palm Beach, assumed duties on August 1 as Chairman of the Department of Ophthalmology of the Medical College of Georgia.

Dr. Luxenberg, 37, received his M.D. degree at the University of Miami School of Medicine. After serving residencies in neurology and ophthalmology, he held a faculty appointment at the University of Iowa College of Medicine and also was associated with the Veterans Hospital in Iowa City.

He is a Diplomate of the American Board of Ophthalmology and is a member of the Palm Beach County Medical Society, the Florida Medical Association and the American Medical Association.

FMA Auxiliary Wins Award

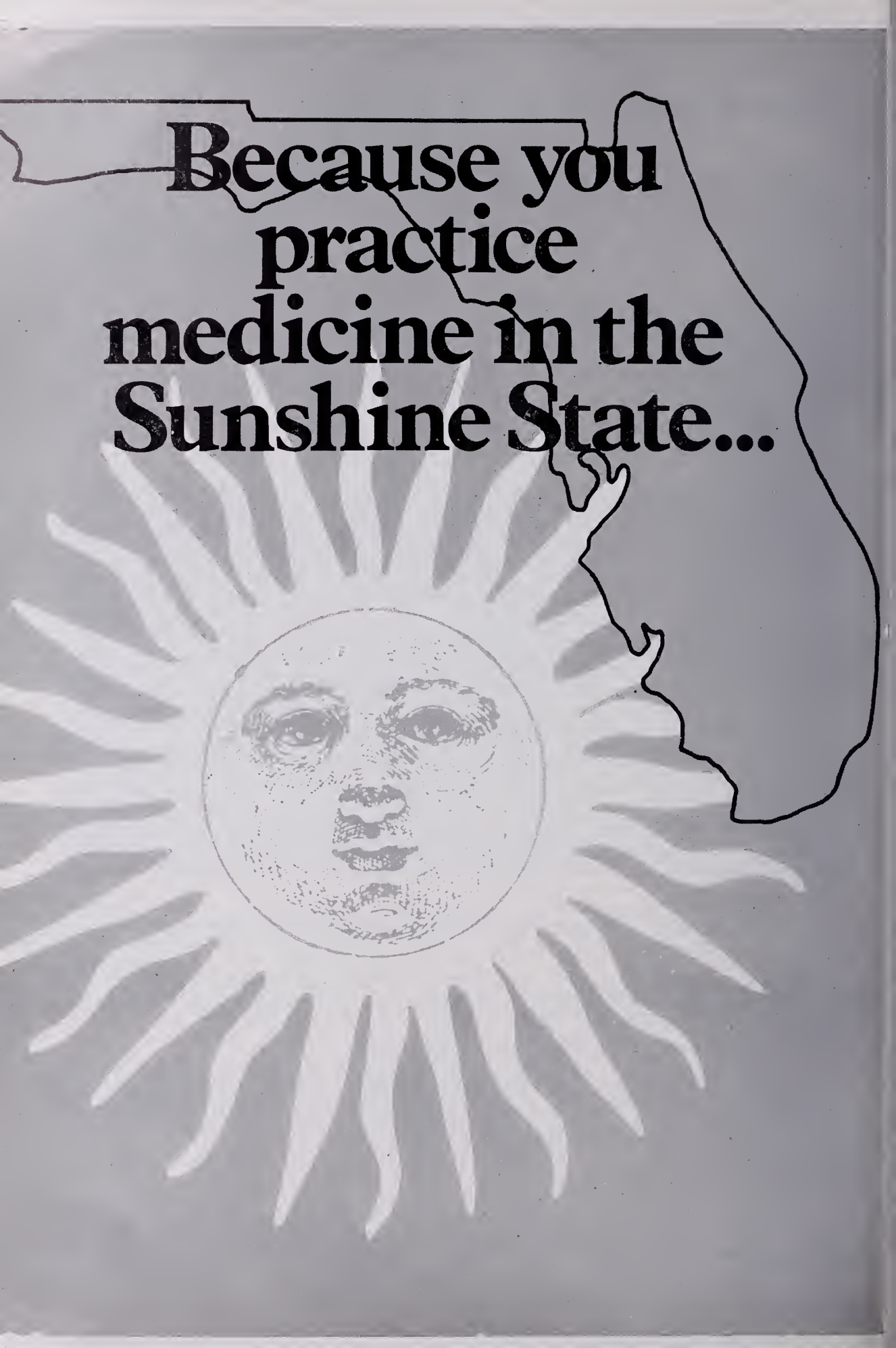
The Woman's Auxiliary to the Florida Medical Association won an award during the Annual Convention of the Woman's Auxiliary to the American Medical Association in San Francisco in June.

The Florida Auxiliary was a regional merit award winner for achieving one of the largest one-year increases in total contributions to the American Medical Association Education and Research Foundation.

Pediatric Fellow

Michael B. Wilhoit, M.D., of Tallahassee, has been elected a Fellow of the American Academy of Pediatrics. Dr. Wilhoit is a member of the Leon-Wakulla-Jefferson Medical Society and the Florida Medical Association.

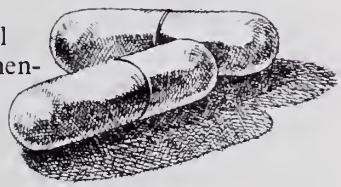
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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Woman's Auxiliary

DON'T TURN THIS PAGE!

Dear Doctor:

Please don't turn this page—we're much more interesting than someone's gallbladder—and prettier, too! Besides, I want to talk to you about your wife:

Have *you* talked with her lately? Not just about the kids leaving the bathroom faucets dripping or the ice cube trays empty or *who's* been using your razor!

Well, I've been talking with her over the past months and Doctor, you made a wise choice, because she's terrific. She's just about as busy as you, with just her everyday activities, getting Johnny's braces repaired (again!), school shoes for everyone, dreaming up clever disguises for your low cholesterol diet, or even pinch-hitting in your office.

Of course, I know her best as a member of your Auxiliary, and what she manages to fit into her busy day would surprise you. She's a new county president in Orlando, mapping out a year filled with busy programs; or a county chairman over in Pensacola, determined to put Health Career programs and information in the local schools; or a state chairman (she's been using your copy machine again . . .) getting communications off to her county representatives.

Your wife was with me in San Francisco when I proudly served as presidential delegate to the Annual Convention of the Woman's Auxiliary to the American Medical Association, where a special tribute highlighted the 50th Anniversary of our national organization. We were treated to a historical review of its birth, when Mrs. Samuel Clark Red, wife of a Houston physician, tried to explain to some rather headstrong physicians (the AMA House of Delegates) that a woman's auxiliary was needed. The program traced the auxiliary's growing involvement in politics and legislation; its work during World War II in recruiting nurses for the U. S. Cadet Nurse Corps, and the service of thousands of members in many other ways during the war years; its leadership in sponsoring Health and Careers Clubs, and the raising of more than 6 million dollars since then for nursing and allied health career scholarships and loans.

We listened while Art Linkletter urged us all to campaign for *realistic* drug education in the schools, starting in kindergarten. . (your wife is already working vigorously in this effort). And to Victor Weingarten, Director of the President's Committee on Health Education, who told us that auxiliaries could be a formidable force in promoting health education programs and for changing legislation, too. Dr. Edward Stainbrook, head of the Human Behavior department of U.S.C. School of Medicine exhorted us to "stop being concerned with changes in the exterior world and stop neglecting your interior world—your community."

Each day we listened, we learned and we watched lovely Mrs. G. Prentiss (Patty) Lee as she presided during the final hours of an exhausting but inspiring year as national president. When she turned the gavel over to newly-installed Mrs. Robert F. (Huldah) Beckley of Lock Haven, Pennsylvania, we all thought "what an awesome task lies ahead for this doctor's wife." (But right here in Florida, Doctor, we have "presidential material" in your auxiliary). We agreed with Mrs. Beckley when she urged us to "press for improvements that will overcome criticism of the profession and help improve the quality of life for all."

Your wife was with me when I joined the fine men of the Florida delegation in their "Florida Room," welcoming friends from all over the country. (We found out that *everyone* likes the Florida men—and so do we).

You would have been proud when your Auxiliary received the Southern Regional Merit Award for the greatest increase in contributions to AMA-ERF, because your wife helped to earn that award, and Florida's three medical schools have

received grants totaling $12,187. It was a tremendous convention, and the 50th Anniversary celebration made it even more meaningful.

Anniversaries seem like a fitting time to reminisce, re-evaluate and perhaps change or improve our image and purposes . . . Your wives will be doing just that when they attend the Fall Board Meeting and Conference in St. Augustine on October 31st through November 2nd. They'll be taking a good look at themselves, and their role in the community. (I wish I could give you all the details of this meeting, but due to the circumstances beyond her control, your new president is a bit behind schedule). She will be hearing about the status of health education in Florida's schools, and among other legislative matters will be those involving health education. National greetings will come from our own Mrs. Linus W. (Jane) Hewit, who is Chairman of Health Education, and from New Mexico, Mrs. Irvin Hendryson. Mrs. Hendryson was Chairman of the Planning Committee for the WA-AMA-sponsored Conference on Health Education last April in Chicago. Health education, from cradle to rocking chair will be discussed, and if all goes well, we'll have some *really* big plans for a future meet.

There'll be time for remembrances of our own, too, as Florida wives get a glimpse of their past, with a few surprise moments for certain men in our medical association. St. Johns County auxiliary will hostess the meet, with their husbands helping out on a tour of St. Augustine's Restored Area and the Spanish Hospital which houses the Museum of Florida Medical History; this is one of the projects you've asked us to support.

During the brief months I'll be serving as your auxiliary president, this page will "Spotlight" your wife, whether she's in Miami or Fort Myers or Kissimmee. She's a very busy lady, a member of your Auxiliary, but she still likes to get in a little tennis or golf or even bridge.

Whether she's a young wife down in Clearwater or a grandmother in Fort Lauderdale, you still come first in her thoughts and plans.

In fact, she's just like me . . . very happy to be,

Dr. Jim's wife
Mrs. James J. (Catherine) DeVito
President, WA-FMA

P.S. Please take this issue home. I wouldn't want your wife to think I was talking about her behind her back.

Mrs. DeVito, 208 Inlet Drive, St. Augustine 23084.



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Medical News

Pediatrician Honored

Lewis A. Barness, M.D., newly-appointed Professor and Chairman of the Department of Pediatrics at the University of South Florida in Tampa has been designated for honor by the American Academy of Pediatrics, who selected Dr. Barness to receive the 1972 Borden Award consisting of $1,000 and a gold medal. Dr. Barness was cited for his contributions to pediatrics in several areas, particularly for his investigation of methylmalonic aciduria.

Dr. Barness received his M.D. degree from Harvard Medical School in 1944.

"Internal Medicine 1973"

A five-day postgraduate course entitled "Internal Medicine 1973" will be presented at the Sheraton Four Ambassadors Hotel in Miami, February 11-16, 1973.

The program is being arranged by the Department of Medicine of the University of Miami School of Medicine. Fees include $150 for practicing physicians and $100 for physicians in training.

Information may be obtained from: J. Bocles, M.D., Department of Medicine, University of Miami School of Medicine, P. O. Box 875, Biscayne Annex, Miami, Fla. 33152.

Florida M.D. Named Editor

Herbert E. Kaufman, M.D., Professor and Chairman of the Department of Ophthalmology and Acting Dean of the University of Florida School of Medicine, has been elected Editor-in-Chief of *Investigative Ophthalmology*.

This journal is the official publication of the Association for Research in Vision and Ophthalmology.

New Neurosurgery Chief

Albert L. Rhoton Jr., M.D., has been appointed Professor and Chief of Neurosurgery at the University of Florida College of Medicine.

Dr. Rhoton comes to Florida from Minnesota where he was a consultant at the Mayo Clinic and Assistant Professor of Neurological Surgery at the University of Minnesota.

A Kentuckian by birth, Dr. Rhoton received his M.D. degree at the Washington University School of Medicine in 1959.

New Chief of Plastic Surgery

Hal Gene Bingham, M.D., has been appointed Professor and Chief of the Division of Plastic and Reconstructive Surgery at the University of Florida College of Medicine in Gainesville.

Dr. Bingham, 47, comes to Florida from a similar position at the University of Missouri Medical Center in Columbia. A native of Kansas, he received his M.D. degree in 1954 from the University of Kansas Medical School, where he also served his residency in plastic surgery.

The new Florida faculty member is a Diplomate of the American Board of Plastic Surgery.

Certification

Harold Baumgarten, M.D., of Jacksonville, has been certified by the American Board of Family Practice. He is a member of the Duval County Medical Society and the Florida Medical Association.

Congress on Medical Ethics

The Fourth National Conference on Medical Ethics will be held at the Washington Hilton in Washington, D.C., April 26-28, 1973.

The program is sponsored by the Judicial Council of the American Medical Association. Among topics that will be explored during next year's Conference are abortion, clinical investigation, euthanasia, genetic engineering, and reproductive technology.

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MEETINGS

Approved by FMA Committee on Continuing Education

National and Regional Meetings Held in Florida

OCTOBER

14 Eleventh Annual Physicians' Seminar on Respiratory Disease, Carillon Hotel, Miami Beach. For information: Florida TB. & Res. Dis. Assn., P. O. Box 8127, Jacksonville, Florida 32211.

16-20 Current Problems in the Therapy of Patients with Coronary Artery Disease, Mount Sinai Hospital, Miami Beach. For information: Frances Richardson, 4300 Alton Road, Miami Beach 33140.

16-21 Course of Instruction in Coronary Care for the Practicing Physician, Jackson Memorial Hospital, Miami. For information: Louis Lemberg, M.D., U. of Miami School of Medicine, Box 875, Biscayne Annex, Miami 33152.

20-21 Postgraduate Course in Otolaryngology for the Family Physician, Playboy Plaza Hotel, Miami Beach. For information: Fredric W. Pullen II, M.D., Box 875, Biscayne Annex, Miami 33152.

27 Conference on "New Advances in the Treatment of Tuberculosis," Hilton Hotel, Jacksonville. For information: Florida TB. & Res. Dis. Assn., P. O. Box 8127, Jacksonville, Florida 32211.

NOVEMBER

3 Lymphoma-Leukemia for Physicians, Manger Hotel, Tampa. For information: John Carbonneau, 1001 S. MacDill Ave., Tampa 33609.

4, 18, 25 Pediatric Pre-Football Game Seminars, J. Hillis Miller Health Center, Gainesville. For information: George A. Richard, M.D., University of Florida, Dept. of Pediatrics, Gainesville 32601.

11 Pediatric Pre-Football Game Seminars, University Hospital Auditorium, Jacksonville. For information: George A. Richard, M.D., University of Florida, Dept. of Pediatrics, Gainesville 32601.

DECEMBER

8-10 "The Spinal Cord Injured Patient," from the Department of Orthopaedics and Rehabilitation, University of Miami School of Medicine, Americana Hotel, Miami Beach. For information: Augusto Sarmiento, M.D., Box 875, Biscayne Annex, Miami 33152.

NOVEMBER

2- 4 International Conference on Trichinellosis, Sheraton-Four Ambassadors Hotel, Miami. Sec.: W. C. Campbell, Ph.D., Merck Institute, Rahway, N. J. 07065.

2- 6 Association of American Medical Colleges, Fontainebleau Hotel, Miami Beach. Pres.: John A. D. Cooper, M.D., 1 Dupont Circle, Washington, D. C. 20036.

6-10 American Society of Tropical Medicine and Hygiene, Deauville Hotel, Miami Beach. Sec.-Treas.: George R. Healy, Ph.D., P.O. Box 15208, Emory University Branch, Atlanta, Ga. 30333.

19-22 Pan American Medical Association, Deauville Hotel, Miami Beach. Dir. Gen.: Joseph J. Eller, M.D., 745 5th Avenue, New York 10022.

DECEMBER

1- 2 American College of Chemosurgery, Balmoral Hotel, Miami, Sec.-Treas.: Richard S. Moraites, M.D., 7721 Montgomery Rd., Cincinnati, Ohio 45236.

2- 7 American Academy of Dermatology, Americana Hotel, Miami Beach. Sec.-Treas.: Frederick A. J. Kingery, M.D., 2250 Northwest Flanders Street, Portland, Oregon 97210.

3- 6 American Society of Hematology, Diplomat Hotel, Miami Beach. Sec.: Steven Robinson, M.D., Beth Israel Hospital, 330 Brookline Avenue, Boston 02215.

4- 6 Southern Surgical Association, Boca Raton Hotel, Boca Raton, Sec.: David C. Sabiston Jr., M.D., Duke University Medical Center, Durham, N.C. 27710.

1973

MAY

21-24 American College of Obstetricians and Gynecologists, Americana Hotel, Miami Beach. Dir.: Michael Newton, M.D., 79 West Monroe Street, Chicago 60603.

JUNE

11-15 Society of Nuclear Medicine, Americana Hotel, Miami Beach. Exec. Dir.: Mrs. Margaret Glos, 211 East 43rd Street, New York 10017.

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Classified Ads

physicians wanted

Family Practitioners

FAMILY PHYSICIAN AND INTERNIST WANTED: To join specialty group in rapidly growing area. Salary and partnership negotiable. Excellent 450-bed new hospital. Contact James Morgan, M.D., 400 Avenue "K," S.E., Winter Haven, Florida 33880.

EXCELLENT OPPORTUNITY FOR FAMILY PHYSICIAN to join two young doctors in fully equipped three man office in Eustis. Our beautiful growing community is near the Ocala National Forest, Disney World, and both coasts. Modern 150 bed hospital is GP oriented with excellent specialty consultants and physician staffed E.R. For information call collect or write: Neal A. Robinson, M.D., North Bay Medical, Eustis, Florida 32726. Phone (904) 357-3120.

URGENTLY NEEDED: GP to join well established physician. Newly constructed office including laboratory and x-ray. Town close to Miami and Palm Beaches, with all sports available. Phone (813)983-8531.

Specialists

INTERNIST, UROLOGIST, GP's.: Outstanding opportunities in progressive nonurban community serving 20,000. Write John H. Parker, M.D., Chief of Staff, Doctors Memorial Hospital, Perry, Florida 32347.

INTERNIST WANTED: For association, greater Miami area, Please send curriculum vitae to C-524, P.O. Box 2411, Jacksonville, Florida 32203.

INTERNIST: Board certified or qualified, internal medicine, to join four other internists. Salary first year; percentage and partnership to follow. Write or call Pompano Medical Group, 2480 Northeast 23rd Street, Pompano Beach, Florida 33062. Telephone (305) 942-0100.

PHYSICIAN WANTED: INTERNAL MEDICINE PREFERRED, for Rainbow Lakes Estates, a community of 1200 residents, 60% retired, plus patients outside of community. Established practice of more than 5000 visits office and house calls last year. OFFER: Rent free, fully equipped, air-conditioned suite of offices, including x-ray room, examining room, plus doctor's office and large reception room and office. Houses available for rent or purchase. Three hospitals radius of 30 miles. Write to Joseph D. Stearns, Route A-2 Box 66, Dunnellon, Florida 32630.

INTERNIST WANTED: Board eligible or certified, preferably with subspecialty, interest in hematology and/or gastroenterology to join flourishing practice in Fort Lauderdale area. Excellent salary and fringe benefits first year, leading to association. Must have Florida license. Please phone (305) 565-6434.

Miscellaneous

WANTED IMMEDIATELY: Private emergency room physician. Corporate group needs fifth physician in teaching hospital, Orlando, Florida. Prefer GP. Florida license required. Contact Bruce S. Webster, M.D. (305) 647-5728 or Robert Gay, M.D. (305) 422-0159.

ADDITIONAL PHYSICIANS URGENTLY NEEDED: GP, internal medicine, obstetrics, pediatrics, and general surgery. Modern office immediately available. Contact I. B. Price, M.D., P.O. Box 819, Quincy, Florida 32351.

PHYSICIANS NEEDED: Tallahassee, Leon County, Northwest. General practitioners, internists and pediatricians in particular. Inquiries regarding practice in this community can be forwarded to J. Orson Smith Jr., M.D., Chairman, Physician Procurement Committee, 1433 Miccosukee Rd., Tallahassee, Fla. 32303. Phone (904) 877-1145.

DUNEDIN, Pinellas County, middle west coast, Clearwater area. Thirty-six physician multispecialty group seeking internist-gastroenterologist, neurologist, pathologist, obstetrician-gynecologist, GP, and emergency room physician. Affiliated general hospital just expanded to 308 beds. Clinic expansion to be completed January 1972. Long range plans for 650 beds and 75-physician clinic. No investment required. Contact Donald M. Schroder, administrator, Mease Hospital and Clinic, P.O. Box 760, Dunedin 33528, phone (813) 733-1111.

INTERNISTS AND GENERAL PRACTITIONER for association—Mid-East Coast Florida. $24,000 guaranteed with excellent potential through participation in partnership. All expenses covered. Liberal benefits. P.O. Box 550, Cocoa, Florida 32922.

EMERGENCY ROOM PHYSICIAN—One opening to start October 1, 1972. Large, modern hospital; liberal benefits. For more details, contact Associate Administrator, Broward General Medical Center, Fort Lauderdale, Florida 33316.

POSITION AVAILABLE: Southern Bell Telephone Company has a full time position available as medical director for State of Florida. Responsibilities are for administrator of the medical program for over 26,000 employees. Prefer internist, G.P. or physician with interest in occupational medicine. Call collect (404) 529-7307 or write Robert P. Cunningham, M.D., Box 2211, Atlanta, Georgia 30301.

CENTRAL FLORIDA AREA: Lovely residential community just above Orlando and Disney World. Many lakes, water activities, and growing family living area! Excellent opportunity for one or two associates in unique, brand new medical center for family practice with OB; surgical privileges if desired at nearby modern 155-bed hospital. Florida license necessary and residency preferred. Initially, no expenses with guaranteed minimum plus percentage. Contact Randall B. Whitney, M.D., 1100 Morningside, Mount Dora, Florida 32757. Phone (904) 383-6129.

OB-GYN, GP, AND/OR INTERNIST WANTED: To join busy ob-gyn and general surgeon. Well equipped Medical Arts Building with low overhead. Small town—near big town in central Florida with excellent hospital and facilities near Disney World complex. Contact Glenn C. Brown, M.D. or Donald A. Brungard, M.D., Medical Arts Building, Haines City, Florida 33844. Telephone (813) 422-4977.

OB-GYN; GENERAL PRACTITIONER; INTERNIST: To join 6 man multi-specialty group. Fine clinic facilities. Across from 400 bed hospital. Salary negotiable, full maintenance, partnership share available within 1 year. Central Florida location within 35 miles of Disney World. Write to: W. A. Ross, Administrator, Bond Clinic, 601 First Street, N., Winter Haven, Florida 33880. Phone (813) 293-1191.

situations wanted

LABORATORY TECHNICIAN, 10 years experience, A.S.C.P., seeking position in doctor's office, hospital or private laboratory. Marcy Alford, 2805 Woodland Dr., Orange Park, Florida 32073. Phone 264-7134.

ALLERGIST, 42, certified pediatric allergy. Academic position university-affiliated hospital, head chest & allergy sections. Experienced chest disease, pulmonary function, tuberculosis, respiratory care, etc. Desires association with established practice, group, or consider progressive hospital lab. Prefer coastal areas. Inquiries: John McCloskey, M.D., 2380 Packard Ave., Huntingdon Valley, Pa. 19006.

RADIOLOGIST: Board certified, Florida licensed. Desires association with group, office, or hospital affiliations. Write C-543, P.O. Box 2411, Jacksonville, Florida 32203.

MATURE STABLE AND EXPERIENCED with industrial and general practice desires position, preferably Tampa area. Florida license. Write C-562, P.O. Box 2411, Jacksonville, Florida 32203.

OBSTETRICS-GYNECOLOGY and GENERAL SURGERY: Board eligible, Florida licensed, general surgeon and obstetrician-gynecologist, seeking group association or partnership in central Florida (Lakeland-Orlando area). Available immediately. Write C-561, P.O. Box 2411, Jacksonville, Florida 32203.

BOARD CERTIFIED GENERAL SURGEON, EXTENSIVE EXPERIENCE, Florida license, American, desires to relocate in Florida. Would like association with group, full time hospital position, partnership or any other surgical opportunity. Experienced in all phases of abdominal surgery, head and neck, thoracic, etc. Please write full particulars. Write C-564, P.O. Box 2411, Jacksonville, Florida 32203.

SITUATION WANTED: Ophthalmologist, single, southern California university residency completed. U.S. Army service expires July 1973. Seeking association or partnership with ophthalmologist or group in south Florida after July 1973. Barry R. Buhler, M.D., Walson Army Hospital, Fort Dix, New Jersey 08640.

FAMILY PHYSICIAN, age 43, Florida licensed, desires association with group or partnership. Available October 1972. Prefer Fort Lauderdale, Plantation, Hollywood area though will consider other opportunities. Write C-559, P.O. Box 2411, Jacksonville, Florida 32203.

practices available

WANTED TO PURCHASE: Established industrial practice in DADE, BROWARD or PALM BEACH COUNTIES. Write full particulars to C-557, P.O. Box 2411, Jacksonville, Florida 32203.

PRACTICE FOR SALE: Fully equipped including EKG, X-Ray and laboratory equipment. Available immediately. Miami Beach. Phone (305) 532-2272 or write C-563, P. O. Box 2411, Jacksonville, Florida 32203.

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MEDICAL CONDOMINIUM FOR SALE adjacent to Memorial Hospital, Jacksonville. Part of large physician-owned condominium complex. Individual space 1,280 sq. ft. available with opportunity for physician to work with architect to create own design. Contact Herbert A. Burke Jr., M.D., 3599 University Boulevard, S., Jacksonville, Florida 32216. Phone (904)737-1880.

OFFICE FOR SALE: Prime location between St. Petersburg and Clearwater, Florida. Architect-designed doctor's office. Seven rooms, 3 baths. Floor plan suited for two doctors. Five ton central heat/air system. Attractive masonry office, seven and one half years old. Ample parking. Soon to be completed hospital within 5 minutes. Ben F. Streets, M.D., 12891 Oakhurst Rd., Seminole, Florida 33542. Phone (813)393-2064.

EXCELLENT OFFICE SPACE AVAILABLE: Gulfport-St. Petersburg. 1500 square feet, 11 rooms, lab, previously occupied by two M.D.'s. Present occupants of building two dentists, one optometrist. Write or call Elmer J. Kouba, D.D.S., 5028 Gulfport Blvd. South, Gulfport 33707. Telephone (813) 343-6197.

OUTSTANDING LOCATION FOR SPECIALIST: St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville 32207. Phone (904) 398-5500.

WONDERFUL OPPORTUNITY for doctor to establish office in new small shopping center at 5650 Washington Street, Hollywood, Florida. Approximately 20,000 apartments and homes in area. Occupancy November 1. Contact Sam Solloway, 9111 E. Bay Harbor Drive, Miami Beach, Florida 33154, Phone 866-5988.

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Next Annual Meeting: May 9-13, 1973, Bal Harbour

JFMA
THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.
VOL. 59, NO. 11
NOVEMBER 1972

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FMA Announces New Professional Liability Insurance Plan

The new FMA sponsored Professional Liability Insurance Plan for members of the Association has been approved by the Board of Governors and appropriate contracts have been executed with Argonaut Insurance Company, which will underwrite the program.

This program was carefully designed and negotiated specifically to meet the needs of our members by appropriate Association representatives; many are of the opinion that it is not only unique but also the finest program in the United States today. The Association was able to obtain every provision it sought for this model program.

Harlan Inc. of Florida, with more than 25 affiliates in Florida, will administer the program with active participation by the Florida Medical Association.

Each member currently insured by the Employers Fire Insurance Company under the current FMA sponsored program will have his new policy issued effective January 1, 1973, based upon the current application on file and completing a simple application form. Others applying for the coverage under this program must complete a new form and have it submitted through their county medical societies.

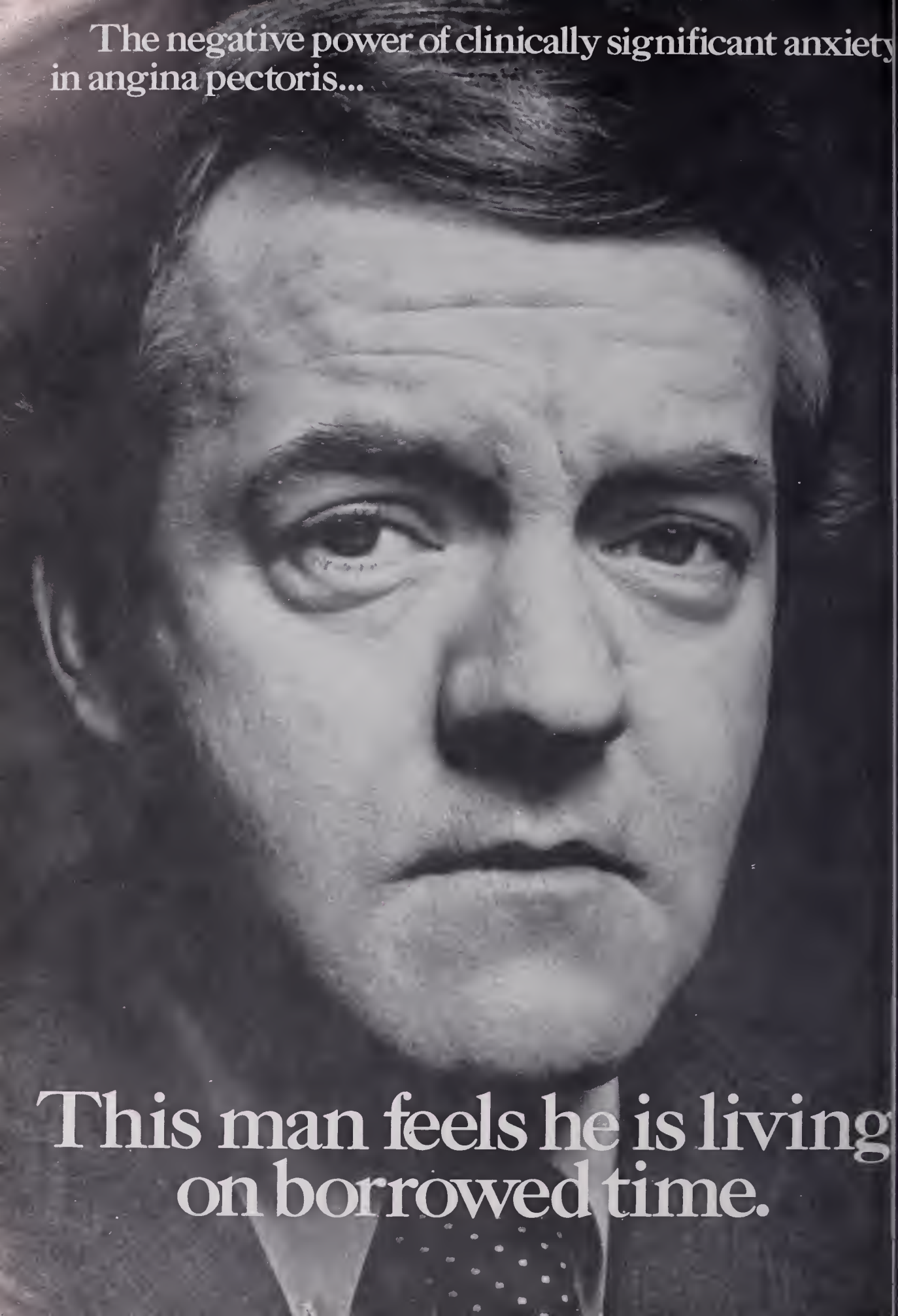
Special features of the program are as follows:

- A 10 per cent reduction in current premiums for those insured under the present program
- Option to pay premium quarterly with no penalty or interest charge
- Minimum limits of $100,000 / $300,000 up to $1,000,000 in the primary contract
- Umbrella coverage will be available from primary limits of $100,000/$300,000 up to a maximum of $5,000,000
- Premises liability will be included at a nominal annual premium
 This will have the same limit of liability as the basic professional liability policy
- Individual policies will be issued for each doctor in a partnership or Professional Association. In addition, a policy will be issued in the name of the partnership or Professional Association
- Centralized claims handling
- Centralized coordination of legal defense
- Program guaranteed minimum of five years
- Centralized administration of all aspects of the program with the Medical Association's active participation
- Medical Society determination of "chargeable losses" of individual physicians
- Complete financial disclosure of the program
- Participation in savings, if any, at the end of a specified time
- Immediate service through toll-free WATS line
- Active defense of all non-meritorious suits.

Application forms and information may be obtained from:

FMA Liability Insurance Plan
c/o Harlan Inc. of Florida
1000 Riverside Avenue, Suite 408
Post Office Box 1319
Jacksonville, Florida 32201
Phone 354-5910 (Toll-free WATS number (800) 342-8349)

The negative power of clinically significant anxiety in angina pectoris...



This man feels he is living on borrowed time.

During anginal attacks, patients may suffer intense apprehension. More frequently, however, they experience a continuing sense of less severe but nonetheless disproportionate anxiety.

Reduction of such clinically significant anxiety is important, since undue emotional stress may precipitate further anginal episodes.

Adjunctive Librium (chlordiazepoxide HCl) may be especially suitable for relief of clinically significant anxiety and emotional tension in anginal patients because of its generally prompt therapeutic effectiveness and wide margin of safety. In a recent double-blind randomized study,* Librium (chlordiazepoxide HCl) was administered for relief of moderate anxiety in 20 anginal patients seen in office practice over a 20-week period. Symptoms of emotional distress related to anxiety were rated at base-line, one week, two weeks and monthly thereafter. Relief was obtained notably early in therapy. The clinical results demonstrated that Librium offers the coronary patient an antianxiety drug that, in the author's opinion, is both effective and safe. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated. (See summary of prescribing information.)

Librium (chlordiazepoxide HCl) is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics and antihypertensive agents, whenever anxiety is clinically significant. The drug should be discontinued after anxiety has been reduced to appropriate levels.

The positive power of adjunctive Librium® (chlordiazepoxide HCl)

10-mg, 25-mg capsules up to 100 mg daily

for moderate to severe anxiety accompanying angina pectoris

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

*Levine, S.: "Angina Pectoris and Emotional Overlay," Scientific Exhibit presented at the Annual Meeting of the Maine Medical Association, Kennebunkport, Me., June 13-15, 1971.

A copy of the Levine study may be obtained from your Roche representative.

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NOVEMBER COVER—New FMA Professional Liability Insurance Program Announcement.



DR. DEAN

President's Page

Guest of the President



MRS. DEVITO

When Dr. Dean extended the invitation to "guest write" his President's Page, he suggested I tell you something of our plans for the coming months.

As you know, county level auxiliaries promote and work on many and varied programs of health education and service such as mental health, safety, communicable and venereal diseases, projects for the aged and, of course, our most frightening problem, drug abuse. Countless members serve on state or local boards of health agencies, hospital or school association, and many other worthwhile endeavors resulting from needs of a particular community. The benefits derived from the work of the membership make YOUR Auxiliary successful.

On the state level we have done some soul-searching, deciding that we should be making a greater impact in our relationship to others (after all, how can anyone ignore an organization of 3,600 women!). We have a responsibility to make our state organization more valuable to its membership and to you, for as you grow, so should we.

Our Plans? After first discussing our ideas with the FMA Executive Committee and getting an enthusiastic endorsement from our own Executive Committee, The Plan went into action: To better direct our efforts toward an overall program, the WA-FMA will sponsor a statewide Conference on Health Education.

The Date? A planning session is scheduled for November 30th at Tampa's International Inn. A projected date of March 7, 1973 for the conference is not yet confirmed.

Participation. Those invited to participate will be state leaders in medical and health professions, FMA Voluntary Health Agencies, educators and other health-involved agencies, and representatives from each county Auxiliary, as well as the communications media.

The Purpose? To provide the opportunity for all participants to learn and discuss via speakers and group sessions, of existing programs, resources and materials available, as well as those which overlap or, are still needed.

The Goal? We hope to establish, through mutual cooperation of all involved, a better understanding of the role each plays and the coordination of their activities; then, the development of a broad program of health education (from cradle to rocking chair) can be initiated with the guidance and sponsorship of FMA, and brought to our communities. Children will come first on the health education priority list, and the need for health educators in schools, and legislation promoting needed programs will be stressed. Guidelines for the conference have been outlined and similar meetings are planned in several states, using the groundwork laid out by AMA/WA-AMA sponsored conference held in Chicago last May; however, ours will be contoured to the needs of Florida with guidance and assistance of FMA.

After reading this, I can hear some of you saying, "everyone's climbing on the health education bandwagon these days," and it's true. Our state and federal government is involved, but it would be wise to remember that the major achievements in health and other endeavors in this country are produced by private and volunteer initiative.

There are thousands of people in this State who could benefit if the successful results of this conference could be brought to them through community action programs. These people look first to their physicians in matters of health and it follows that the logical "catalyst" in a health education conference should be the medical association.

We will do the work if you'll provide us with an encouraging word . . . or maybe two.

MRS. JAMES J. (CATHERINE) DEVITO
PRESIDENT, WA/FMA
(BETTER KNOWN AS "DR. JIM'S WIFE")

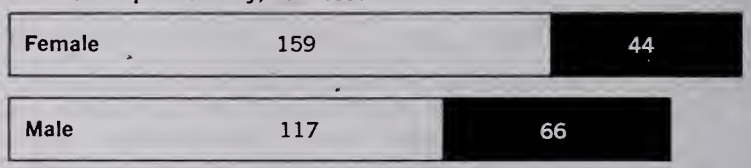
What it means to live and work in Tipton County, Tennessee

Persons who are white and over 40 have one chance in four of having solar keratoses... which may be premalignant

An epidemiologic study* conducted in Tipton County, Tennessee, revealed that 28.5% of white persons over 40 had solar keratoses; most had multiple lesions. Cluster sampling projected an estimated prevalence of 32.5% for white males and 19.5% for white females.

Though this is an unusually high percentage of affected persons, these lesions can occur in any white population, wherever people work or play out of doors.

Prevalence of solar keratoses in white persons over 40 in Tipton County, Tennessee



*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.



Solar, actinic, senile keratoses

Called by many names, the typical lesion is flat or slightly elevated, brownish or reddish in color, papular, dry, adherent, rough, sharply defined; usually multiple lesions, chiefly on exposed portions of the skin.

Sequence/selectivity of response

Erythema in areas of lesions may begin after several days of therapy; height of reaction (only in affected areas)* usually occurs within two weeks, declining after discontinuation of therapy. Since this response is so predictable, lesions that do not respond should be biopsied to rule out the presence of a frank neoplasm.

Cosmetic results

Cosmetic results are highly favorable. Incidence of scarring is low—important with multiple facial lesions. Efudex should be applied with care near the eyes, nose and mouth.

5% cream–a Roche exclusive

Only Roche formulates the 5% cream... high in patient acceptability... high in clinical efficacy, especially for lesions of hands and forearms... economical.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Multiple actinic or solar keratoses.

Contraindications: Patients with known hypersensitivity to any of its components.

Warnings: If occlusive dressing used, may increase inflammatory reactions in adjacent normal skin. Avoid prolonged exposure to ultraviolet rays. Safe use in pregnancy not established.

Precautions: If applied with fingers, wash hands immediately. Apply with care near eyes, nose and mouth. Lesions failing to respond or recurring should be biopsied.

Adverse Reactions: Local—pain, pruritus, hyperpigmentation and burning at application site most frequent; also dermatitis, scarring, soreness and tenderness. Also reported—insomnia, stomatitis, suppuration, scaling, swelling, irritability, medicinal taste, photosensitivity, lacrimation, leukocytosis, thrombocytopenia, toxic granulation and eosinophilia.

Dosage and Administration: Apply sufficient quantity to cover lesion twice daily with nonmetal applicator or suitable glove. Usual duration of therapy is 2 to 4 weeks.

How Supplied: Solution, 10-ml drop dispensers—containing 2% or 5% fluorouracil on a weight/weight basis, compounded with propylene glycol, tris(hydroxymethyl)aminomethane, hydroxypropyl cellulose, parabens (methyl and propyl) and disodium edetate.

Cream, 25-Gm tubes—containing 5% fluorouracil in a vanishing cream base consisting of white petrolatum, stearyl alcohol, propylene glycol, polysorbate 60 and parabens (methyl and propyl).

an alternative to conventional therapy

Efudex®

(fluorouracil)

cream/solution

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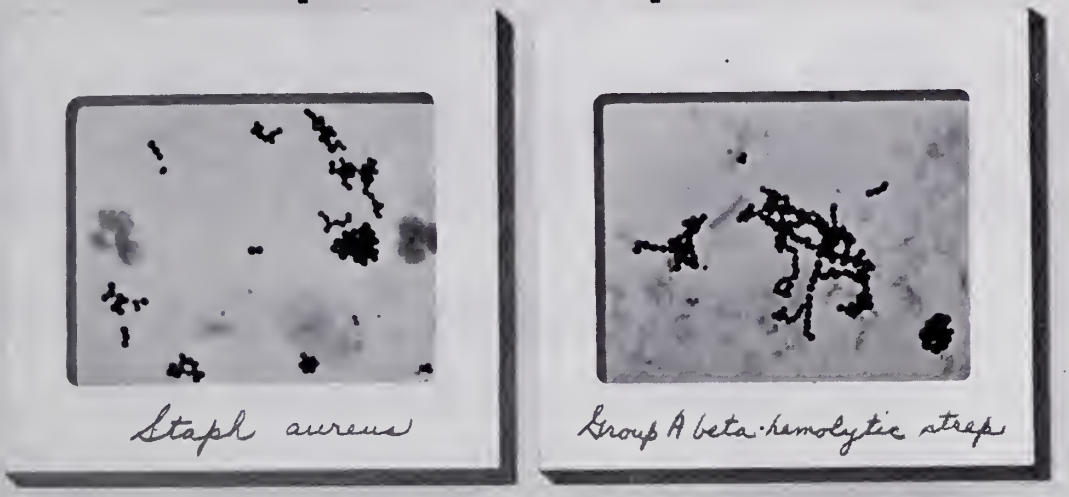
Pinworm therapy is often a family affair





Contraindications: History of hypersensitivity to thiabendazole.
Warnings: If hypersensitivity reactions occur, drug should be discontinued immediately and not resumed. Rarely, erythema multiforme has been associated with thiabendazole therapy; in severe cases (Stevens-Johnson syndrome), fatalities have occurred. Because CNS side effects may occur quite frequently, activities requiring mental alertness should be avoided. Safe use in pregnancy or lactation has not been established.
Precautions: Ideally, supportive therapy is indicated for anemic, dehydrated, or malnourished patients prior to initiation of anthelmintic therapy. In presence of hepatic or renal dysfunction, patients should be carefully monitored.
Adverse Reactions: Most frequently encountered are anore
nausea, vomiting, and dizziness. Less frequently, diarrhea,
epigastric distress, pruritus, weariness, drowsiness, giddin
and headache have occurred. Rarely, tinnitus, hyperirritabi
numbness, abnormal sensation in eyes, blurring of vision,
xanthopsia; hypotension, collapse; enuresis; transient rise
cephalin flocculation and SGOT; perianal rash, cholestasis
parenchymal liver damage; hyperglycemia; transient leukop
malodor of the urine, crystalluria, hematuria; appearance o
Ascaris in the mouth and nose. Hypersensitivity reactions

For staph...or strep...or both



Most bacterial infections of the skin are caused by *Staphylococcus aureus,* Group A beta-hemolytic streptococci, or a combination of both organisms.

To combat these infections efficiently, your antibiotic should be effective against both staph *and* strep—whether they occur alone or in combination.

Yet many antibiotics—such as ampicillin and penicillin G and V—are ineffective against the increasingly prevalent penicillinase-producing strains of *S. aureus.* And others, like the tetracyclines, are often ineffective against either staph or strep.

Cleocin HCl (clindamycin HCl hydrate, Upjohn) is one antibiotic that has proved effective against both Group A beta-hemolytic streptococci* and penicillinase-producing *S. aureus.*

A recent comparison of clindamycin and penicillin V was conducted in 151 pediatric patients with impetigo. In the 147 patients who completed the study, clindamycin achieved a bacteriological and clinical cure rate in 68 of 74 patients as opposed to only 53 of 73 patients for penicillin V.[1] Of the staphylococcal organisms isolated, 27 of 51 were found to be penicillin resistant; these patients were placed in the clindamycin group.

In multiple clinical studies of clindamycin in skin and soft tissue infections, including abscesses, wounds, cellulitis, furunculosis and impetigo, the causative organisms—whether staph or strep or both—were eradicated in 326 of 333 patients from whom follow-up cultures were obtained. Clinical resolution of the infection was achieved in 367 of 377 patients[1] Significantly, among those with superficial skin and soft tissue infections, mixed staph and strep were found in 50 of 174 patients from whom cultures were obtained.

In clinical usage, mild to moderate morbilliform skin rashes have been the most frequently recorded side effects, and rare instances of erythema multiforme have been observed.

Transient neutropenia (leukopenia) and eosinophilia have been reported. Rare reports of agranulocytosis and thrombocytopenia have been made. No direct etiologic relationship to concurrent clindamycin HCl therapy could be made in any of the foregoing.

There have also been recent reports of cases of severe and persistent diarrhea necessitating drug discontinuance. This diarrhea has been occasionally associated with blood and mucus in the stools, and has at times resulted in an acute colitis.

In summary, Cleocin is a potent antibiotic. Because of its dual effectiveness against staph and strep—the two most commonly encountered pathogens in skin and soft tissue infections—Cleocin may prove valuable in such infections requiring immediate treatment.

*With beta-hemolytic streptococcal infections, treatment should continue for at least 10 days.

[1] Data on file, Medical Research Files, The Upjohn Company.

Cleocin® 150 mg capsules **HCl**
clindamycin·HCl hydrate, Upjohn



For further prescribing information, please see following page.

Cleocin® HCl
clindamycin HCl hydrate, Upjohn



...for staph, or strep, or both

Clinical and bacteriologic responses of patients with skin and soft tissue infections treated by 55 investigators with Cleocin HCl (clindamycin HCl hydrate, Upjohn)*

Infection	No. of Patients	Pathogens	Clinical Response: Excel. or Good	Clinical Response: Poor	Bacteriologic Response: No. of Pts. Evaluatable	Bacteriologic Response: Organisms Eradicated
Abscesses, wounds, & furuncles	156	*S. aureus* – 107 staph, other – 12 β-strep – 10	151	5	129	126
Cellulitis	38	*S. aureus* – 21 staph, other – 1 β-strep – 8	38	–	30	30
Superficial skin & soft tissue – mostly impetigo	183	*S. aureus* – 41 Mixed β-strep & staph – 51 staph, other – 1 β-strep (74 Group A) – 81	178	5	174	170

*Data on file, Medical Research Files, The Upjohn Company.
Note: With β-hemolytic streptococcal infections, treatment should continue for at least 10 days.

Each preparation contains:	Clindamycin HCl hydrate equivalent to clindamycin base
150 mg Capsules	150 mg
75 mg Capsules	75 mg

Cleocin (clindamycin) is a new semisynthetic antibiotic produced from the parent compound lincomycin and provides more *in vitro* potency, better oral absorption and fewer gastrointestinal side effects than the parent compound.

Indicated for infections caused by susceptible strains of: Staphylococci – upper and lower respiratory tract infections, skin and soft tissue infections; Pneumococci – upper and lower respiratory tract infections; Streptococci – upper respiratory tract infections (injectable benzathine penicillin is considered to be the drug of choice in treatment and prevention of streptococcal pharyngitis and in long-term prophylaxis of rheumatic fever), lower respiratory tract infections, skin and soft tissue infections. Also indicated as adjunctive therapy in dental infections due to susceptible organisms. Bacteriologic studies should be performed and *in vitro* susceptibility to clindamycin should be tested.

CONTRAINDICATIONS: This drug is contraindicated in individuals with a history of hypersensitivity to preparations containing clindamycin or lincomycin.

WARNINGS: **Cases of severe and persistent diarrhea have been reported and have at times necessitated discontinuance of the drug. This diarrhea has been occasionally associated with blood and mucus in the stools and has at times resulted in an acute colitis.**

Usage in pregnancy: Safety for use in pregnancy has not been established.

Use in the newborn: Until further clinical experience is obtained, Cleocin HCl (clindamycin HCl hydrate) is not indicated in the newborn (infants below 30 days of age).

PRECAUTIONS: Prescribe with caution in atopic individuals. During prolonged therapy, periodic liver and kidney function tests and blood counts should be performed. The use of Cleocin occasionally results in overgrowth of nonsusceptible organisms – particularly yeasts. Should superinfections occur, appropriate measures should be taken as indicated by the clinical situation.

ADVERSE REACTIONS: *Gastrointestinal:* Abdominal pain, naus vomiting and diarrhea, or loose stools may occur. Cases of seve diarrhea associated with blood and mucus in the stools have be reported (see "Warnings").

Skin and Mucous Membranes: Generalized mild to moderat morbilliform-like skin rashes are the most frequently reported c all adverse reactions. Other skin reactions, including urticaria, a of less frequent occurrence. Rare instances of erythema multiforme have been reported.

Hypersensitivity Reactions: A few cases of anaphylactoid reactions have been reported. If such a reaction occurs the dru should be discontinued. The usual agents (epinephrine, corticosteroids, antihistamines) should be available for emerge treatment of serious reactions.

Liver: Jaundice and transient abnormalities in liver function tests (elevations of alkaline phosphatase and serum transamina have been observed during Cleocin (clindamycin) therapy.

Hematopoietic: Transient neutropenia (leukopenia) and eosinophilia have been reported; relationship to therapy is unknown. No irreversible hematologic toxicity has been reporte

DOSAGE AND ADMINISTRATION: *Adults:* Mild to moderately severe infections – 150 to 300 mg every 6 hours. Severe infections – 300 to 450 mg every 6 hours.

Children: Mild to moderately severe infections – 8 to 16 mg/kg/day (4 to 8 mg/lb/day) divided into three or four equal doses. Severe infections – 16 to 20 mg/kg/day (8 to 10 mg/lb/da divided into three or four equal doses.

Note: With β-hemolytic streptococcal infections, treatment should continue for at least 10 days to diminish the likelihood o subsequent rheumatic fever or glomerulonephritis.

HOW SUPPLIED: Cleocin HCl (clindamycin HCl hydrate) is available as: *150 mg Capsules* – Bottles of 16's and 100's. *75 mg Capsules* – Bottles of 16's and 100's. *Susceptibility Disks* 2 μg. *Susceptibility Powder* – Vials.

For additional product information, see your Upjohn representative or consult package insert. MED B-6-S (LNU-5) JA72-216

Upjohn The Upjohn Company, Kalamazoo, Michigan 49

It's over 30. Trust it.



Remarkably well tolerated.
Highly predictable.
Prompt, smooth, gentle action.
Saves your patients money.

Butisol SODIUM®
(SODIUM BUTABARBITAL)

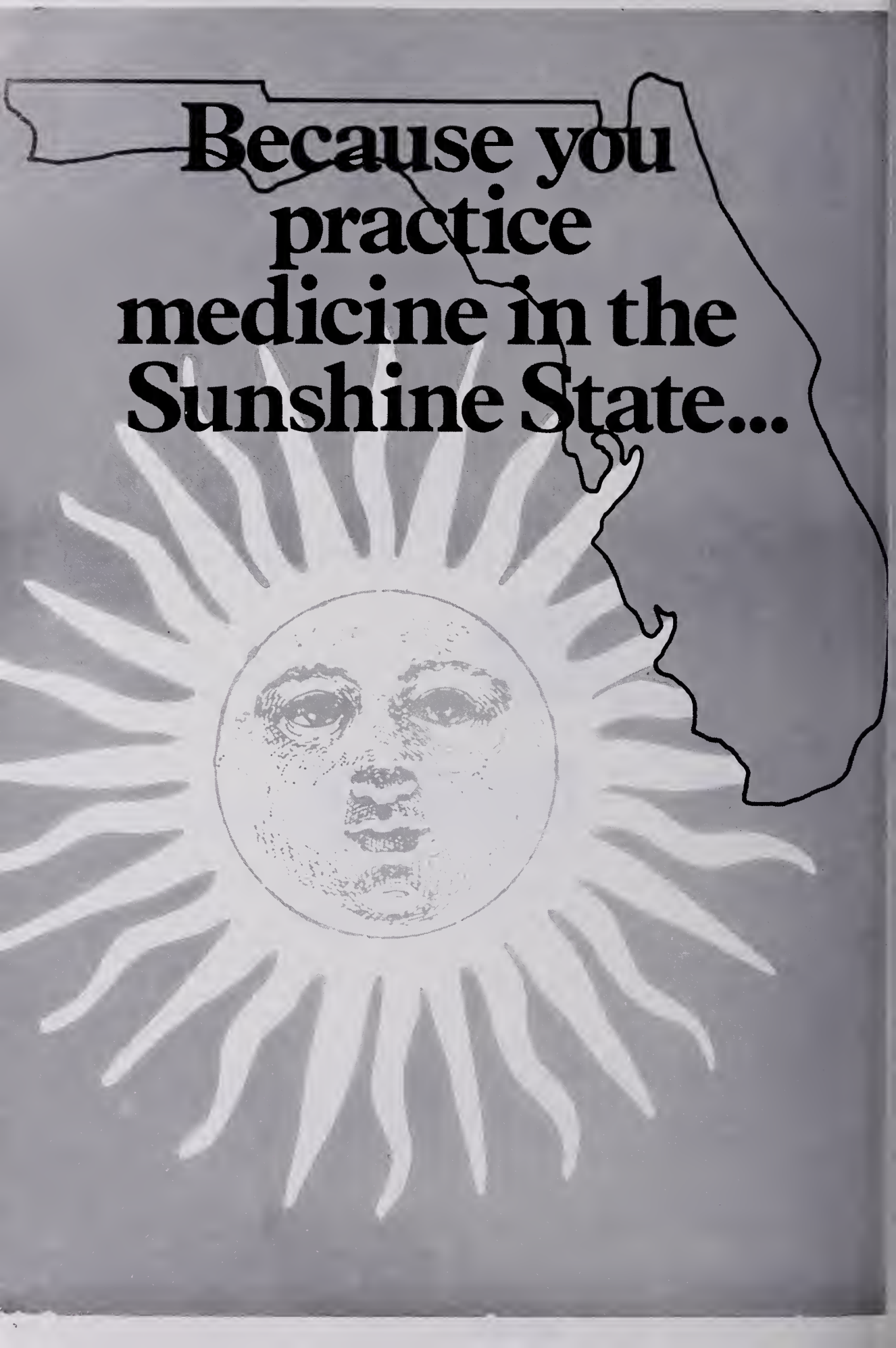
Tablets 15 mg., 30 mg.
Elixir 30 mg./5 cc. (alcohol 7%)

Indications: Useful as a daytime sedative when mild sedation is required.
Contraindications: Porphyria or sensitivity to barbiturates. **Warning:** May be habit forming
Precautions: Exercise caution in moderate to severe hepatic disease. Elderly or debilitated patients may react with marked excitement or depression. **Adverse Reactions:** Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and systemic disturbances are seldom seen.
Usual Adult Dosage: For daytime sedation, 15 mg. to 30 mg. t.i.d. or q.i.d.
Also available: BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg., 30 mg.,

McNeil Laboratories, Inc., Fort Washington, Pa. 19034

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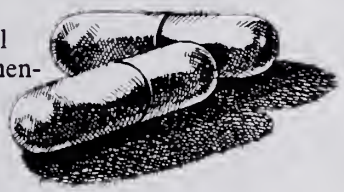
Because you practice medicine in the Sunshine State...



You carry one of the heaviest patient loads in the country. Since this may include a number of patients with gastritis and duodenitis... you should know more about Librax®

Helps reduce anxiety-related G.I. symptoms

A patient may blame his attacks of gastritis or duodenitis on "something he ate" but contributing factors may be his job, marital problems, financial worries or some other unmentioned source of stress and excessive anxiety that exacerbated the condition. Whether it is "something he ate" or "something eating him," adjunctive Librax can help. Librax offers both the antianxiety action of Librium® (chlordiazepoxide HCl), that can help relieve excessive anxiety, and the dependable anticholinergic action of Quarzan® (clidinium Br), that can help reduce gastrointestinal hypermotility and hypersecretion.



Patient-oriented dosage — up to 8 capsules daily in divided doses

For optimal response, dosage can be adjusted to suit patient needs—1 or 2 capsules, 3 or 4 times a day.

To help relieve anxiety-linked symptoms in gastritis and duodenitis

adjunctive

Librax®

ROCHE

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

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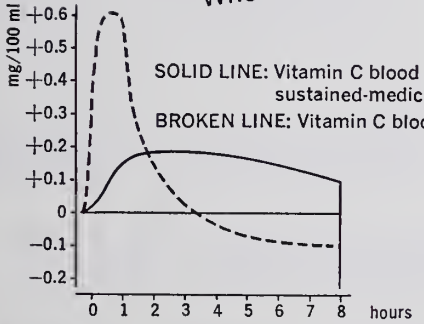


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1. Riccitelli, M. L.: Vitamin C Therapy in Geriatric Practice, J. Amer. Geriatrics Soc. 20: 34, 1972.

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Medical News

Health Association Honors Dr. Peek

The Florida Public Health Association has presented Eugene G. Peek Jr., M.D., of Ocala with its Meritorious Service Award. Dr. Peek is President of the Advisory Council to the Florida Divison of Health. The presentation was made at the Association's meeting in Hollywood on September 22.

The Meritorious Service Award, inaugurated in 1959, is awarded to those who, in the opinion of the judges, have made an outstanding contribution to the health and well-being of Florida's citizens.

Dr. Peek's citation was as follows:

Eugene Goodbred Peek, Junior, Doctor of Medicine, is a tower of strength to the community of man in Florida. Were he not a physician we would still be honoring him, for he is a working leader in so many segments of human endeavor. But he is a physician, a doctor—a statesman of medicine we are so proud to call colleague. Dr. Peek is not the leader of one program, the author of one mighty deed. He has for over twenty years thrown the weight of his immense intelligence and personality behind all of the many programs and projects with which we have tried to solve the problems of public health. He takes his duties as President of the Advisory Council to the Division of Health very seriously, studying the matters which come to the Council's table carefully and in depth. He has been supportive and helpful in developing and carrying on the Public Health Program of the state. As a member of the Board of Governors of the Florida Medical Association he has served most ably and tirelessly as an effective liaison with the medical profession. He has been one of the state's busiest and most effective public health workers—and on his own time.

It is, therefore, the pleasure and privilege of the Florida Public Health Association to honor Doctor Eugene G. Peek, Junior, with the Meritorious Service Award for 1972.

New Professor at Miami

Eric Reiss, M.D., has been appointed Professor of Medicine and Vice Chairman of the Department of Medicine at the University of Miami School of Medicine.

Dr. Reiss came to Miami from Chicago, where he was Professor of Medicine at Pritzker School of Medicine, University of Chicago. He is the author of more than 75 scientific publications, many of them dealing with burn treatment and endocrinology.

A graduate of Randolph Macon College, Dr. Reiss received his medical degree in 1948 at the Medical College of Virginia.

Florida Gets Duke Physician

D. Robert Howard, M.D., 35-year-old assistant professor of community health sciences at Duke University, has been selected to head the family practice program at the University of Florida.

A 1962 graduate of the University of Wisconsin School of Medicine, Dr. Howard has been directing the Physician's Associate Program at Duke. The program he will supervise at Florida was developed jointly by the College of Medicine's Department of Community Health and Family Practice and Alachua General Hospital.

At Gainesville, Dr. Howard will hold the academic rank of Associate Professor in the Department of Community Health and Family Medicine.

Two Vie for FMA Presidency

Two well known members of the Florida Medical Association have been proposed by their county medical societies as candidates for President Elect of FMA, subject to the election at the 1973 Annual Meeting.

The Duval County Medical Society said it would nominate Thad M. Moseley, M.D., of Jacksonville, and the Escambia County Medical Society announced the candidacy of William M. C. Wilhoit, M.D., of Pensacola. Both men have served in many important positions in organized medicine, and both are former presidents of their county medical societies.

Dr. Wilhoit, a 51-year-old psychiatrist, received his M.D. degree from Duke University in 1944. He has been a member of the Board of Governors of FMA since 1966 and for three of those years has been on the Executive Committee.

Dr. Moseley is a general surgeon who received his medical degree at Vanderbilt University School of Medicine in 1943. A former Editor of *The Journal of the Florida Medical Association,* Dr. Moseley was instrumental in the creation of the Foundation for Medical Care in Duval County and currently is its board chairman.

Both candidates served in the medical corps of the armed forces during World War II, Dr. Moseley in the Army and Dr. Wilhoit in the Navy.









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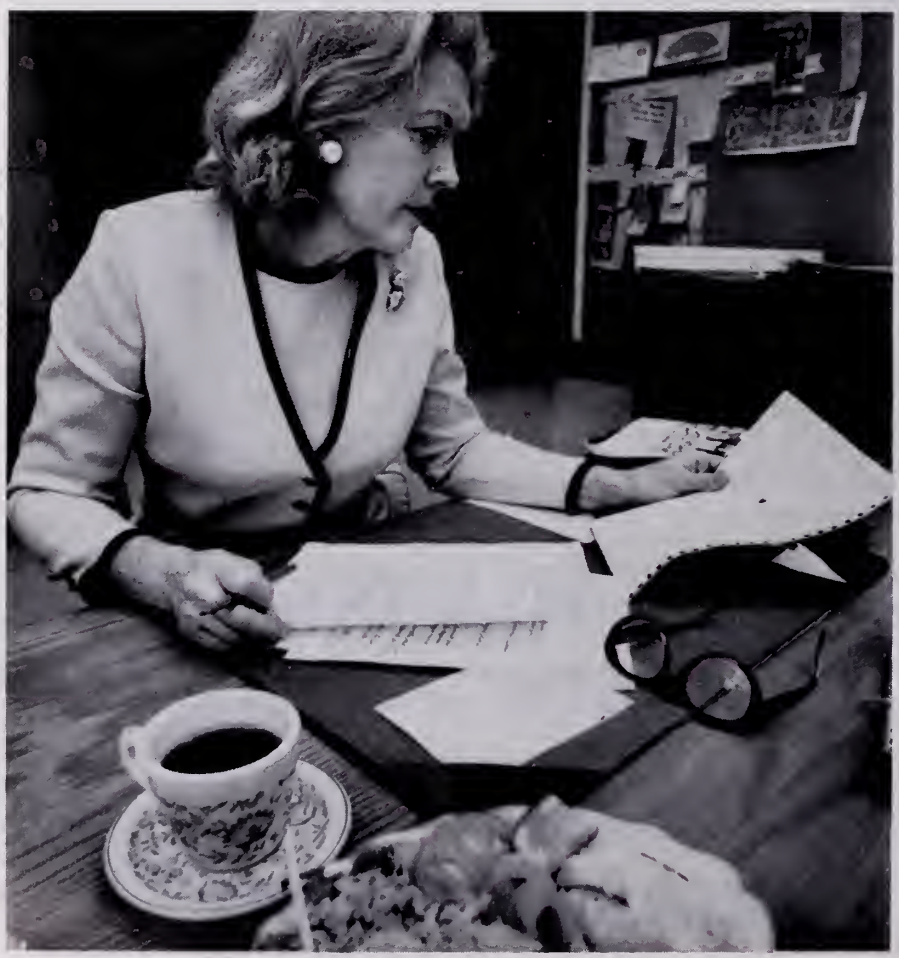
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FEEDBACK - from Pearl Street

Red Tide—Some Medical Aspects

Recently, national attention was focused on the northeastern coastal area of the United States while it was experiencing a red tide phenomenon. The red tide receives its name from the reddish discoloration of littoral waters which occurs when certain microscopic marine protozoans "bloom" to high concentration. These organisms are dinoflagellates, primarily *Gonyaulax* and *Gymnodidium* species. Huge fish kills are common during a red tide due to a heat stable alkaloid, saxitoxin, elaborated by these pigmented protozoans and reduced oxygen tension in the waters. When ingested by humans, saxitoxin produces a syndrome characterized by the rapid onset of circumoral and acral paresthesias, followed by muscle weakness which can progress, in fatal cases, to respiratory arrest. The severity of disease is mainly determined by the dose of toxin ingested. Shellfish are the primary source of saxitoxin for man, as they are filter feeders and tend to concentrate saxitoxin in their tissues when the red tide is present. Cooking toxin-containing clams and mussels does no good as the toxin is heat stable. Paralytic shellfish poisoning is treated by removal of unabsorbed toxin (emesis and catharsis) and, in severe cases, by supportive respiratory care. The red tide is a frequent visitor to Florida shores with several episodes in the recent past. The New England red tide in September produced 33 reported human cases of paralytic shellfish poisoning, and Florida physicians should be alert to the possibility of this disease when a red tide occurs here.

Enterovirus Isolates

Isolations of enteroviruses for the period June through Aug. 72 have recently been reported by the State Bureau of Laboratories. Aseptic meningitis and FUO were the predominant disease syndromes and the patients were pediatric for the most part. Specific viruses isolated from fecal specimens include ECHO viruses 4, 6, and 11 and Coxsackie B3. Specimens from which successful isolation was made came mainly from Duval County physicians, but Hillsborough, Pinellas and Polk Counties were also represented. This is the normal pattern for summer enteric virus disease.

Flu and Flu-like Disease

Influenza is a clinical syndrome characterized by headache, fever, malaise, coryza, cough and myalgia. There are few, if any, gastrointestinal symptoms. Clinically, there is nothing to differentiate infections caused by the different influenza virus types. Also, a number of other viruses can cause influenza-like illness indistinguishable from true influenza. These include the adenoviruses, rhinoviruses ("cold virus"), Coxsackie viruses, ECHO viruses, and several others. The Virus Unit of the State Bureau of Laboratories is prepared to aid physicians in the diagnosis of respiratory disease with complement fixation tests against six group antigens: influenza A, influenza B, para-influenza 1, para-influenza 3, adenovirus and mycoplasma. Paired serologic specimens, taken at least 10 days apart within 2 weeks from the date of onset and accompanied by a clinical description of the respiratory illness, will be run. However, during heavy periods of respiratory disease activity, the demand for service may exceed the laboratory's capability.

Influenza Vaccine—An Update

The U.S. Public Health Service has just advised that an antigenic shift has occurred in the influenza A virus now prevalent throughout the world. As of this writing (13 Oct.), no influenza A activity has yet been documented in the continental United States this flu season. Influenza experts are unclear as to whether or not this change in the influenza virus portends a big flu season. The epidemic potential of the new flu strain cannot now be accurately evaluated. The PHS also advises that the currently available influenza vaccines offer at least some protection against the new strain, should it become a problem. Physicians are strongly urged to give influenza vaccine to those of their patients who meet the criteria for immunization (See Feedback, Vol. 59, No. 10). Prompt and accurate reporting of influenza and influenza-like disease to local health departments is encouraged, as only valid and up-to-date information can avert the panic that occurs in the vacuum of ignorance.

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The Problem of Sickle Cell Disease

GORDON R. ENGEBRETSON, PH.D.

Abstract: This paper presents a review of Sickle Cell Disease including anemia and trait, the nature and scope of the problem, manifestations, methodologies for detection and diagnosis, management of the patient and psychological aspects of the disease.

Sickle cell anemia was first described in 1910 by J. D. Herrick[1] when he observed peculiarly shaped red blood cells. Pauling[2] and his associates in 1949 demonstrated that the anemia was a disorder of the hemoglobin molecule and termed it a molecular disease. The hemoglobin variant causing sickle cell anemia is commonly referred to as sickle cell-hemoglobin S (Hb-S).

Each of the hemoglobin molecules consists of one molecule of globin to which four molecules of heme (an iron complex molecule) are attached: the molecules of globin being composed of two alpha chains and two beta chains (Fig. 1). It has been shown further that alpha chains contain 141 amino acid residues or units, while beta chains contain 146 amino acid residues.[3]

Pauling[4] and his co-workers suggested that the sickling phenomenon observed in the Hb-S variant might be due to an environment in the hemoglobin molecule which, upon deoxygenation, caused the hemoglobin to precipitate out in the cell, thereby changing its shape. They observed that the hemoglobin carried a positive electrical charge greater than that of normal hemoglobin and postulated the difference was due to the

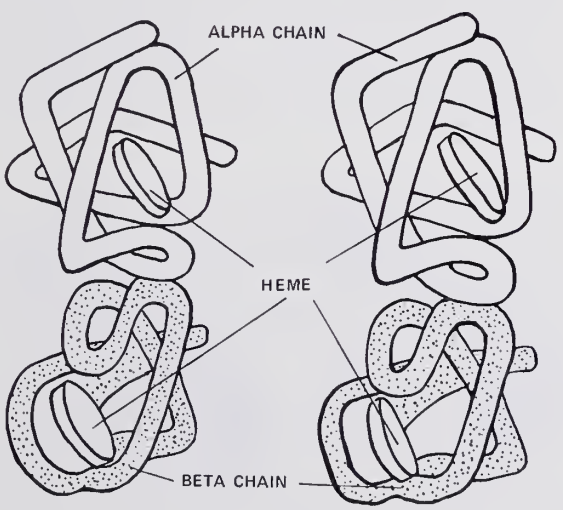


Figure 1

Hemoglobin molecule consisting of two alpha chains and two beta chains to which four molecules of heme are attached.

Dr. Engebretson is Deputy Director of the Florida Regional Medical Program.
This work was supported by funds provided by Title IX of the Public Health Act; however, the findings and conclusions reported herein do not necessarily represent the views of the Public Health Service.

change in the number and types of ionizable groups.

Ingram,[5] through chromotography and other techniques, demonstrated that a substitution of two uncharged valine acid residues for two charged glutamic acid residues in the Hb-S molecule altered the electric charge from that of a normal hemoglobin molecule (Hb-A). It was later shown by Hunt and Ingram[6] that one glutamic acid residue is replaced by a valine residue at the sixth position from the amino acid end (N-terminus) in each beta chain of a Hb-S molecule (Fig. 2). A change in the order of acid residues in the structural gene responsible for coding the synthesis of hemoglobin beta chains can account for such an altered amino sequence in the variant beta chain. By substitution of the base uridine for the base adenine in the structural gene, a valine for glutamic acid substitution occurs during the synthesis of globin, producing abnormal hemoglobin.[7] These substitutions make the thermodynamics for hydrophobic bonding between two variant hemoglobin molecules favorable.

Sickling

The process of sickling[8] is caused by the inherited hemoglobin abnormality of the cells. In cases of low oxygen tension wherein the hemoglobin molecules become deoxygenated, the solubility of Hb-S decreases 50-fold while normal deoxygenated Hb-A solubility decreases only twofold.[9,10] The resultant tactoids (liquid crystals) form rigid gels[11] with a marked increase in the viscosity of the sickle cell. In this state, the red blood cells assume a characteristic sickle shape, are fragile and rapidly destroyed in circulation.

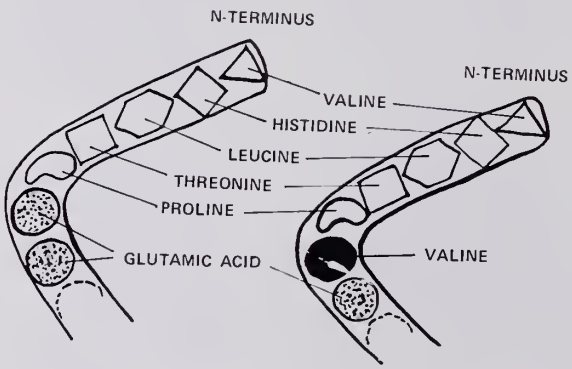


Figure 2

Comparison of normal and abnormal (sickle cell) hemoglobin beta chains with valine for glutamic amino acid substitution near the N-terminus.

The life span of these cells is only 30-40 days, rather than the normal 120 days for healthy cells. Although a person with the disease can synthesize new blood cells, he tends to become anemic by virtue of the increased rate of destruction of red cells over and above their normal production rate. When some extrinsic factor reduces oxygen tension in certain parts of the circulatory system or in certain organs, the viscosity of the blood increases through precipitation of the red cells, impeding blood flow through the area. Oxygen extraction by the surrounding tissue from the slowly moving blood further reduces the available oxygen, increasing the number of cells which become sickled, thereby further increasing the viscosity and slowing the flow of blood to the area.[12]

Manifestations of the Disease

Sickle cell anemia is a chronic disease marked by periods of exacerbation, or crises, which may be triggered by stress situations, including viral or bacterial infections, cold, vasospasms, hypoxia, or any situation causing hypoxia or reduced circulation resulting in prolonged periods of deoxygenation in the peripheral vascular system.[13] Organs most frequently involved are the brain, kidneys, spleen, liver, and bones with resulting ischemia and infarction. The course of the disease varies from person to person, but the earlier the onset of symptoms, the poorer the prognosis.[14]

Clinical manifestations of sickle cell anemia are rare in infants before the second or third month, after which time the fetal hemoglobin has largely been replaced by the sickle hemoglobin.[15] Symptomatology when present, is generally very bizarre and nonspecific. Major complaints include irritability with no apparent cause, colic, failure to thrive, recurrent fever with no specific etiology, abdominal distention associated with colic, jaundice, intermittent nausea and vomiting.[16] Physical findings include hepatomegaly, painful swelling of hands and feet, pallor, recurrent infection, heart murmurs, and splenomegaly.[17]

In older children, the most common symptom is a painful crisis characterized by fever, severe pain in the extremities, chest, back and/or abdomen. Occasionally an aplastic or aregenerative crisis may occur characterized by marked pallor unaccompanied by any significant degree of icterus and a sudden, temporary cessation of erythrocyte production. Stasis with sludging and eventual occlusions occurs in small capillaries,

terminal arterioles and venules. Invariably, tissue ischemia, infarction and necrosis result from such occlusions.

A hemolytic, or hyperhemolytic, crisis may occur preceded by an infection during which the individual exhibits such symptoms as anemia, tiredness, dyspnea, exertion and tachycardia. Jaundice and dark urine accompanied by pain in different parts of the body are also typical findings. Other complaints[18] include headache, lethargy, meningismus, convulsion, aphasia, epistaxis, hematuria, priapism, and, not infrequently, anorexia, vomiting, easy fatiguability, and recurrent fever are encountered with or without an apparent infection.

Children with sickle cell anemia have been found to weigh less, be of shorter and thinner stature, barrel-chested, exhibit enlarged, protruding abdomens, and have thin extremities.[19]

When found in adults, symptomatology is not much different from children. Adult patients are characterized by narrow shoulders and hips, decreased height, exaggerated upper dorsal kyphosis, lumbar lordosis and hypogonadism. Often seen in adults but rarely among children are chronic leg ulcers over the internal or external malleoli, which may be simple, multiple, unilateral or bilateral. Spontaneous gross hematuria is more common while hyposthenuria is common in both children and adults.[20,21]

Sickle Cell Trait (Sicklemia)

Unlike persons afflicted with sickle cell anemia, those with sicklemia have a smaller percentage of abnormal hemoglobin-S in their blood. The cells continue to behave like normal red blood cells and, under normal circumstances, sickle cell anemia will never actually develop.

These patients have a reduced capability to withstand certain physical stresses and may collapse under hard physical exertion. Women[22] with the trait tend to experience more difficult pregnancies with some increase in perinatal mortality. Such persons should avoid conditions leading to hypoxia. In the event general anesthesia is required sufficient oxygen should be given to sustain a pO_2 level above that capable of precipitating a sickle cell crisis.

Scope of the Problem

Sickle cell anemia and trait are found primarily in the black race. Their occurrence in the white population is negligible.[23] The incidence of the Hb-S varies among American blacks, depending upon their ancestry, with reports of heterozygous Hb-S (trait) ranging from 7%[24] to 13.4%.[25] A 10% incidence of the heterozygous Hb-S variant is commonly used as a baseline figure.

The incidence[26] of the homozygous Hb-S varies from 0.3% to 1.3%. In eastern and central Africa, the homozygous state is more prevalent, and in one instance of the pigmoids in East Africa, a figure of 45% was reported.[27] There has been some speculation that sicklemia spread through Africa from southern India by noting a 33.1% incidence figure[28] of the heterozygous state in negroid Veddoids of southern India.

It has been postulated[29] that sickle cell hemoglobin had its origin as a mutant which gave a selective advantage to populations exposed to the malaria parasite Plasmodium falciparum. The protective gene reduces the pO_2 level in the blood to a point where the parasite is not able to thrive.

Foster et. al.,[30,31] in comparing sickle cell anemia with other important childhood diseases, note that it is the most prevalent (Table 1).

Table 1.—Incidence of Some Important Childhood Diseases per 100,000 Population.

Sickle Cell Anemia	250	(Negro Births)
Diabetes Mellitus	40	(2:1 : White:Negro)
Acute Leukemia	35	(Children under 15, majority white)
Cystic Fibrosis	34	(Births 98% White)
Muscular Dystrophy	20	
Phenylketonuria	10	(White Births)

Figure 3 demonstrates the Mendelian principle in propagation of the homozygous and heterozygous hemoglobin variant. With one heterozygous parent (Fig. 3a) the probability of a heterozygous progeny is 50%. With two heterozygous parents (Fig. 3b) the probability of a heterozygous offspring is 50% and a probability of 25% for a homozygous offspring, and so forth.

Based on the commonly accepted incidence figures and the population data in Table 2, it can be seen that the prevalence of the heterozygous Hb-S variant is probably about 105,000 in Florida. Of these, slightly over 42,000 possible heterozygotes are in the most common childbearing ages of 15 to 45 years.

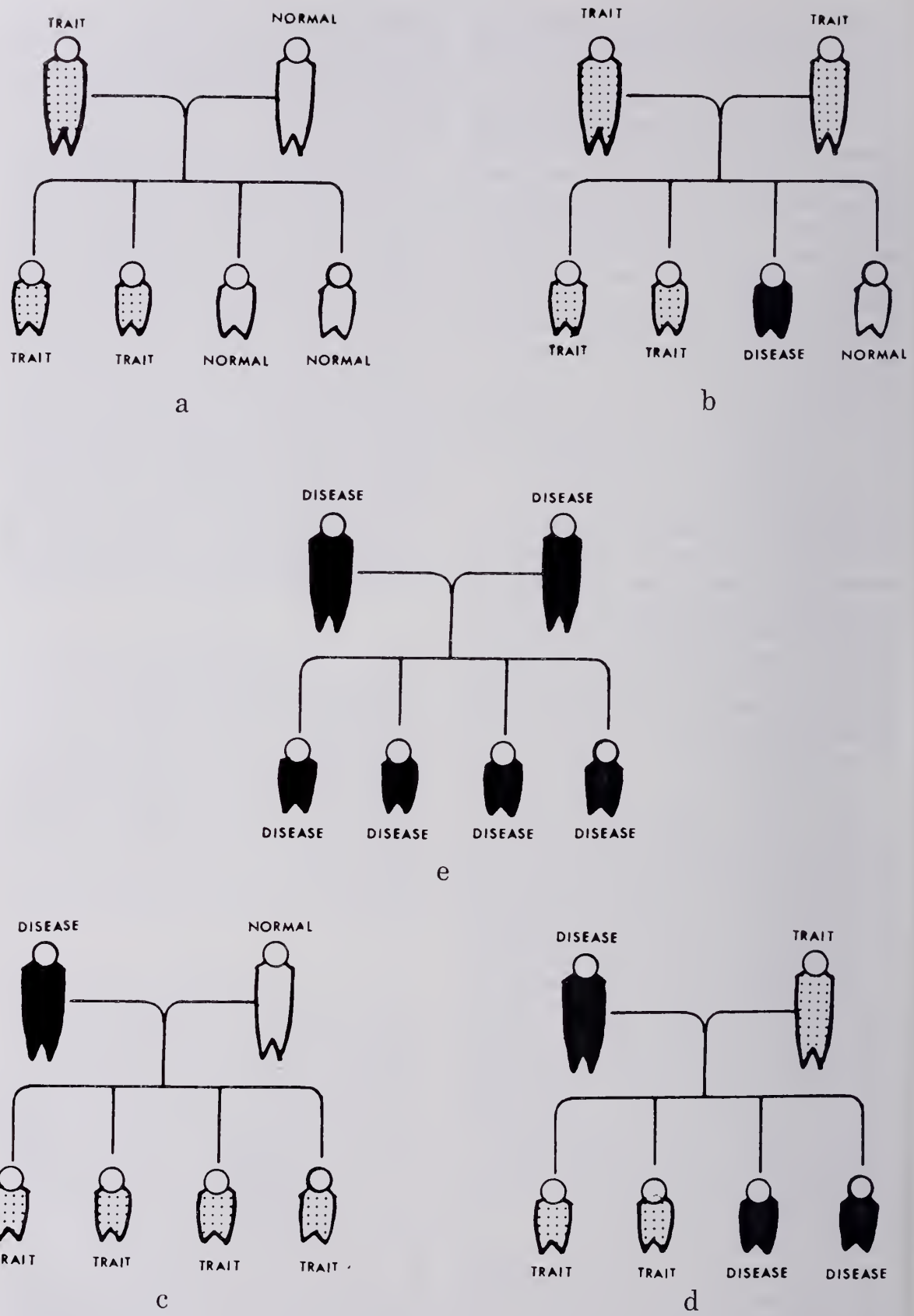


Fig. 3.—Schematic representation of the Mendelian Principle demonstrating probabilities of offspring having sickle cell anemia (disease) or sickle cell trait.

Table 2.—Florida Black Population, 1970 Census Figures.

Under 5 years	117,895
5-14 years	271,751
15-25 years	190,416
26-34 years	122,892
35-44 years	109,617
45-54 years	93,736
55-64 years	75,400
65 years and over	67,871
All ages	1,049,578

Of the possible 105,000 blacks in Florida with the Hb-S variant, 10% or nearly 10,500 can be expected to have sickle cell anemia. Based on the 1969 black birth rate (latest figures available), this pool of heterozygotes and homozygotes increases at an annual rate of over 2,600 and 260, using an incidence figure of 10% and 1% for the heterozygous and homozygous states, respectively. The pool decreases at a rate of slightly over 1,000 for heterozygotes and slightly over 100 for homozygotes, based on the statistics for the 1969 black death rate in Florida, again using the 10% and 1% incidence of the heterozygous and homozygous states, respectively.

Ingram[32] notes that only 20% of homozygotes survive to have children. Song[33] attributes this to his estimation of a relative "fitness" level of 25% when homozygotes are compared to heterozygotes. It therefore seems reasonable to assume that the propagation of the variant gene in Florida's black population is due to reproduction by heterozygotes.

The steady state of the genetic pool in Florida, then, is probably increasing at an annual rate of about 1,600 or more (the difference between the annual birth rate and annual death rate) for heterozygotes, and about 32 (20% of the difference between the birth rate and death rate) for homozygotes.

Detection and Diagnosis

Sickle cell anemia mimics a wide variety of diseases. Deaths are not adequately recorded. McGavack et. al.[34] found in reviewing 214 cases of sickle cell anemia that 45% showed incorrect diagnoses. Of these, 39 were diagnosed as acute abdominal conditions, of which 16 were operated upon. Other diagnoses included obstructed ileus, tuberculous peritonitis, salpingitis, appendicitis, peritonitis due to perforated ulcer, and cholecystitis.

The procedure in a detection test is to cause the variant hemoglobin to become deoxygenated, precipitating, and directly or indirectly observing the sickled erythrocytes. Early methods utilized direct observation of stained slides which were allowed to set for several hours. The testing time can be reduced by treating the sample with sodium metabisulfite to hasten the deoxygenation process. Direct microscopic observation of the sickled erythrocytes is the confirming diagnosis.

It is not only important to detect the sickled cells, but it is also necessary to distinguish the various hemoglobin variants from one another. At least seven are known to sickle including S, C (Harlem), C (Georgetown), I, Bart's, Alexandra, and Memphis/S. Isaacs[35] has shown that virtually any molecular species of hemoglobin can be made to sickle under the appropriate conditions.

A differential test developed by Itano[36] is based upon the reduced solubility of deoxygenated Hb-S in a phosphate buffer system. Since this original work, it has been shown that several other hemoglobinopathies demonstrate low solubilities in aqueous systems.[37-39] A modification of the Itano test developed by Heller and Yakulis[40] also possesses some of the specificity limitations of the Itano test.

The Sickledex® test was originally introduced as specific for detection of hemoglobin-S.[41] After the erythrocytes have been lysed, it is believed that the hemoglobin-S forms a liquid crystal system with unique physical properties including birefringence, circular dichroism, paramagnetism, and light scattering. It was predicted[42] on theoretical grounds that other non-S sickling hemoglobinopathies would give false positives for the Sickledex test.

Another detection test soon to be released commercially is also based upon the physical properties of variant hemoglobins from lysed erythrocytes. It has been stated[43] that this new test will exhibit a degree of specificity unavailable in screening procedures currently used.

The Murayama Test[44] which was the first specific one for Hb-S is predicated on unique features of the molecular pathology of Hb-S. While the test is stated to be relatively easy to perform, it is reported not to be convenient for mass screening programs.

In order to solve the problem of lack of specificity in most tests, electrophoresis is often utilized. A recent paper[45] describes a compre-

hensive screening program for hemoglobinopathies based on a ten-minute cellulose acetate electrophoresis procedure.

Management of the Patient

There is no cure for sickle cell anemia or trait. In a recent article, Desforges et. al.[46] state that the physical management of patients should be directed toward two fundamental objectives:

1. Minimizing the frequency and severity of several types of crises the patient may experience and protecting him from permanent, cumulative effects of the sickling phenomenon—the infarctions that may inhibit or halt functioning of practically any of his vital organs.
2. Minimizing his psychological response to a painful, debilitating, dangerous, and frightening condition that never gets much better.

They further state that infection, though the precise mechanism is not understood, is a causative factor in precipitating a sickle cell anemia crisis.

Prevention and control of infection is required. Whenever the patient exhibits symptoms of a cold, sore throat, or other minor upset, his temperature should be monitored, and, if it rises a degree or two above normal, or persists for more than 24 hours, measures to reduce it should be taken. Some pediatricians furnish 250,000 unit penicillin tablets for a fever over 101 F. or may prescribe routine prophylactic doses of pencillin during certain susceptible periods.

Sickling in the retinal and scleral vessels is not uncommon and, therefore, an ophthalmic examination should be done periodically. In order to prevent, as much as possible, a sickle cell anemia crisis, physical and emotional stresses, traumatic incidents, chilling, or environments where oxygen is in short supply are to be avoided.

Folic acid deficiency has been implicated in some anemic crises, and in some cases supplemental folic acid has been advised. Maintenance of adequate hydration has also been stated to be critical to the management of the patient.[47] Urine production of at least 800 cc. for a child of four years or 3 or more liters per day for an adult has been suggested as a measure of adequate hydration.

In describing the stable sickle cell anemia patient, Desforges further points out that his hemoglobin will range from 5.5 to 9.5 Gm.%; hematocrit from 17-29%; reticulocytes from 5-30%, with an average of 12%; nucleated red cells from 1-20, with an average of 3; WBC from 12,000-35,000, with an average of 20,000. A higher than normal serum bilirubin ranging from 1.5-4.0 mg.% is also observed.

In a crisis, fluids, analgesics and rest, while palliative, are the recommended treatment. Some home care can be rendered for pain crises. Mild crises may require at least 50 cc. of fluid per kg. of body weight per day plus enough analgesic to provide substantial relief. Codeine and morphines may be used, although usually not for the patient at home. Some physicians prescribe an alkalizing agent such as sodium bicarbonate or polycitrate to prevent acidosis which promotes sickling. In time, the patient and his family can develop their own guidelines regarding the degree of difficulties which can be handled at home and those for which the patient should be transferred to the hospital.

Diggs[48] recommends the following as home care treatment:

1. Keep the patient warm using a hot tub bath, hot water bottle or heating pad.
2. Massage the patient.
3. Administer adequate fluids.
4. Provide a diet high in protein and carbohydrates.
5. Administer sodium citrate through the crisis periods.
6. Administer analgesics for pain.

A number of clinical treatment methodologies are currently under investigation. Urea therapy has received much attention as a means for reversing sickling. This procedure is based on Murayama's[49] thesis that in the deoxygenated state the molecular conformation of sickle cell hemoglobin forms hydrophobic bonds. While urea is known to weaken hydrophobic bonds, maintenance of a blood urea nitrogen level in therapeutically effective ranges can produce a number of complicating effects, including dehydration, sclerosis and thrombophlebitis at the infusion site, tissue necrosis, drowsiness, and possible depression of the respiratory center. Investigation of drugs that disrupt or prevent hydrophobic bonding are also reported by Cerami and Manning[50] in their experiments with potassium cyanate.

It has been proposed[51] that there may be some unknown endogenous factors which precipi-

tate a sickle cell crisis. Some identifiable factors or co-factors acting synergistically in the blood may trigger the event when their concentrations fall below a critical level. Some medical intervention aimed at replacing the deficient factor, inhibiting its synthesis, restricting its intake, or increasing its utilization may be indicated under these conditions. It has been found that sickle cell hemoglobin which has been highly purified by dialysis will not aggregate and that magnesium ion and low molecular weight dialyzable co-factor may be required for aggregation of the sickle cell hemoglobin molecules.

Other treatment methodologies include transfusion with packed blood cells, oxygen therapy, papaverine, and sodium citrate administration.

Psychological Aspects

In order to minimize the psychological response to the disease, the patient and his family should be made aware that transmittal of the disease is a genetic accident to which both parents contributed but for which they, presumably, are not consciously responsible.[52] It is also important to explain the expectations of a serious condition of anemia with its concomitant low tolerance for physical activity. The family should be made aware that the patient will experience episodes of intense pain which may necessitate hospitalization. The child will, from time to time, miss his schooling, and the family should be prepared to provide opportunities for his education during these periods. The physical development of the patient will be slower than his healthy siblings and he should be prepared for this fact. He will be shorter and weigh less. The disease will not affect his mental capacity unless he experiences some sickling-induced complication.

For those detected with trait, somewhat different counseling is indicated. The patient should be made aware of situations in which he could experience difficulties. Genetic counseling and family planning should also be considered for these patients.

The counseling process should address three objectives—to increase the knowledge of the patient and his family regarding good health practices, to familiarize the patient and his family with the nature of and problems associated with sickle cell disease, and to provide persons with the trait or anemia an understanding of the possible consequences to their future offspring.

President Nixon recently signed a bill from Congress which allocates $25 million a year for three years to combat sickle cell anemia. Testimony at Congressional hearings before the House resulted in the proposed legislation which provided funds for research, screening, treatment, and counseling for those affected.

HEW Secretary Richardson appointed a National Advisory Committee on Sickle Cell Anemia which is headed by the Associate Director for Health Programs of the National Urban League. The National Institutes of Health (NIH) have identified $6 million to stimulate the development of a small number of comprehensive centers for research, treatment, and education of sickle cell patients. In May, 1972, it was anticipated that $1 million would be earmarked for research grants within the National Heart and Lung Institute with the remaining $5 million to be divided equally for research and service as recommended by the National Sickle Cell Advisory Committee (Table 3). Of the $2.5 million research monies, approximately $1 million was said to be allocated to research centers for the purpose of experimentation in the diagnosis and treatment of sickle cell disease. The remaining $1½ million will probably be made available for research grants. Of the funds allocated for services, approximately $1½ million will go for development of local screening and education centers with the remaining to be allocated for the establishment of service clinics.

Table 3.—Allocation of National Institutes of Health Sickle Cell Disease Funds.

	RESEARCH	SERVICE	TOTAL
Centers	$1.0 million	$1.5 million	$2.5 million
Clinics	——	$1.0 million	$1.0 million
Grants	$1.5 million	——	$1.5 million
	$2.5 million	$2.5 million	$5.0 million

The University of Miami, Division of Family Medicine, the Miami Model Cities Program, and others have cooperated to develop an application for a sickle cell education program in the greater Miami area. Support for this program has been requested from the NIH funds previously mentioned.

The Florida Regional Medical Program, through its Health Services Committee and its Regional Advisory Group, have identified sickle cell disease as a program of potential interest for Florida.

References are available from the author upon request.

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Leiomyoma of the Duodenum A Case Report

Sibu P. Saha, M.D. and C. B. Roesch, M.D.

Abstract: A case of leiomyoma of the duodenum is reported and the literature is briefly reviewed. The patient presented with malena, diagnosis was established by upper GI series. The lesion was removed by local excision. The patient responded successfully to surgery and returned to his normal routine.

Leiomyoma of the duodenum is a rare clinical entity, easily overlooked, but one which responds successfully to surgical resection. It often presents no symptoms and usually is an incidental finding at autopsy. When symptomatic it is manifested by hemorrhage, obstruction, intussusception or the presence of a palpable abdominal mass. Early accurate diagnosis depends upon the diligence of the search and a sufficiently high index of suspicion on the part of both clinician and radiologist.

This paper presents the clinical history of a patient with leiomyoma of the duodenum treated surgically and briefly reviews the literature. Perhaps this discussion will result in the clinician becoming more aware of these lesions.

Report of Case

The 55-year-old man was admitted to the hospital on October 6, 1969 because of weakness continuing about three weeks. The history revealed no evidence of epigastric pain, indigestion, weight loss or jaundice. He smoked two or three cigarettes each day, denied any alcohol ingestion in the past eight years and only a "fair amount" prior to that time. He had no known allergies but had had two lumbar disc operations and a thyroidectomy in 1953.

Physical examination revealed a massively obese abdomen and widening of the right inguinal ring without descensus. There was evidence of tarry stool.

The hemoglobin was 6.9 Gm.% and hematocrit 21.7%. The EKG revealed an early ventricular repolarization. Chest x-ray showed no abnormalities and the barium enema was not remarkable. An upper GI series revealed a polypoid mass 1½" in diameter protruding posteriorly from the wall of the second portion of the duodenum in the region of the ampulla of Vater and no widening of the C-loop (Fig. 1).

On the 7th hospital day, laparotomy and duodenotomy were performed. There was no evidence of hepatic, metastasis, nodal or cul-de-sac seeding. A 5-6 cm. dumbbell-shaped polypoid mass was removed from the second portion of the duodenum at about the junction of the middle and lower third (Fig. 2). It was ulcerated like a giant nipple. The cut section appeared rubbery with intra-tumor hemorrhages (Fig. 3). The frozen section gave evidence of a mesodermal tumor but it could not be determined whether the lesion was benign or malignant. There was no obvious invasion by the tumor mass and clinically it appeared benign. It was treated by local excision, plastic repair of the duodenum and T-tube choledochostomy. Histopathological examination classified the lesion as a benign intramural leiomyoma of the small intestine, ulcerated. The Armed Forces Institute of Pathology confirmed the finding.

The postoperative course was uneventful. The patient was discharged on October 20 and resumed work within a short time.

Discussion

Incidence of leiomyoma of the small intestine is low. Chont[1] examined 20,003 surgical specimens removed from the small bowel and discovered three leiomyomas. Straus and O'Kane[2] found 15 reported cases of leiomyoma of the duodenum prior to 1952 and added one case of their own. Raiford[3] reviewed 56,500 autopsies and found 13 benign tumors of the duodenum; none were leiomyomas. Rankin and Newell[4] reported six myomas of the duodenum from the Mayo Clinic up to 1933. Olson, Dockerty and Gray[5] collected all cases from the Mayo Clinic and found 26 benign tumors of the duodenum; nine were myomas. Hoffman and Grayzel[6] in 1945 reviewed 64,300 surgical specimens and 4,480 autopsies and found 19 cases of benign tumor of the duodenum,



Figure 1

none were leiomyomas. Ebert et al[7] reported two myomas of the duodenum in 25,000 autopsies. Shandalow[8] encountered three myomas in 2,698 consecutive autopsies performed between 1940 and 1954 at the Cumberland Hospital; only one was in the duodenum. River et al[9] in a comprehensive review of the literature in 1956 found 1,399 small bowel tumors; only 32 of them were described as leiomyomas of the duodenum.

Myomas in the small bowel occur most commonly in the ileum and jejunum, less frequently in the duodenum. In the small intestine myomas are second only to adenomas in frequency of occurrence. According to Cressman[10] 50% of leiomyomas of the duodenum occur in its descending portion. There is no predilection of this smooth muscle tumor for either sex. The age distribution spreads from youth to old age, with an average of 46 years.[11,12]

Myomas are classified according to their relationship to the bowel wall on which clinical manifestation depends. They may be entirely submucosal, entirely subserosal, or dumbbell, combining the features of the first two types. Our case belongs to the dumbbell type. The incidence of malignant degeneration is high in the submucosal type. According to Marshall and Cherry[13] the mechanism of bleeding differs in the two types.

In many instances, leiomyoma cannot be distinguished from leiomyosarcoma except by careful microscopic examination and even this may leave doubt. Clinically it usually presents with hemorrhage, obstruction or the presence of a palpable mass in the abdomen. Rarely does the lesion perforate and produce symptoms of peritonitis. On occasion it gives rise to a syndrome closely resembling that of duodenal ulcer, namely melena, epigastric pain and radiologic evidence of pyloroduodenal spasm.[14]

Weinstein and Roberts[15] reported a case of leiomyosarcoma of the duodenum where a barium filled fistulous tract was found communicating from the tumor cavity to the duodenum.

Roentgenology has been very helpful in diagnosis of leiomyoma of the duodenum. This necessitates not only a painstaking examination but also alertness to the less common lesions of this region. Although rare, leiomyoma of the duodenum may prove fatal unless diagnosed early and removed surgically.

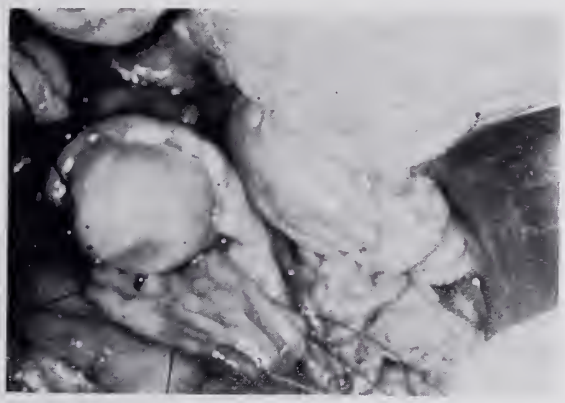


Figure 2

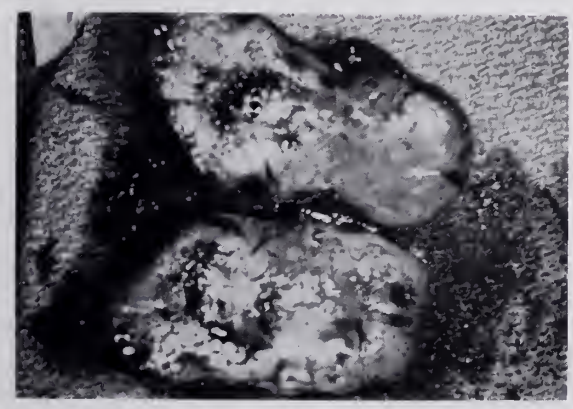


Figure 3

Summary

A case of leiomyoma of the duodenum is reported and the literature is briefly reviewed. The lesion was detected early and responded successfully to surgery. The patient returned to his normal routine.

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Curable Chronic Abdominal Wall Pain

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Abstract: Localized tenderness within the abdominal wall and related structures should be specifically sought out in patients who present with persistent abdominal pain, and wherein no cause has been found. The writer's experience with 17 such patients is described. An awareness of this entity could obviate needless or potentially hazardous diagnostic study, including laparotomy. Local infiltration with an anesthetic and glucocorticoid may afford prolonged relief, especially when the tenderness is localized in or adjacent to an incisional site.

Undiagnosed chronic abdominal pain poses a recurrent enigma for the clinician and surgeon. The differential diagnosis is lengthy, encompassing many local and systemic disorders.[1] The purpose of this report is to emphasize (1) the surprising frequency of localized tenderness within the abdominal wall and related structures as the cause of such unexplained discomfort and (2) the prolonged relief and apparent curative response that can be achieved by infiltration with a local anesthetic and glucocorticoid.

Some physicians undoubtedly recognize this entity. I have not located any specific reference to it, however, in an analysis of the recent literature. Furthermore, there was no mention of it in the prior clinical records of 17 personally-observed patients in whom it proved to be the basic etiology. Many had undergone extensive investigations at various clinics. Moreover, laparotomy was being actively considered in several of these patients because their persistent pain raised the possibility of underlying abdominal or retroperitoneal pathology.

Abdominal Pain Localized in or Adjacent to an Incisional Site

Twelve patients were seen for longstanding abdominal pain with the following strikingly similar features:

Their discomfort did not suggest the more typical patterns of visceral pain, but was localized to the immediate area of a healed abdominal incision. A clearcut relationship to aggravation by motion could be elicited only in several. (Patients 6 and 8). Multiple operations had been performed through or around the same incision in Patients 2 and 4.

A diagnosis of "adhesions" or of a "functional" or "psychophysiologic gastrointestinal" disorder commonly had been rendered after extensive and prolonged study, generally because the patient was still concerned over the persistent pain. The constant discomfort of a right inguinal herniorrhaphy, performed 3½ years earlier on a 42-year-old male, was attributed to "excessively tight suturing."

Exquisite tenderness in or adjacent to the incisional scar could be elicited, usually reproducing their presenting pain. A keloidal reaction was detectable in three patients (2, 7 and 8)—all white.

Infiltration of the tender site with a local anesthetic (1% or 2% lidocaine) and a corticosteroid preparation on one or several occasions effected prompt and ultimately permanent relief of the abdominal pain. A formula containing two betamethasone esters (Celestone Soluspan*) was employed in eight of these patients because of certain desirable pharmacologic properties described earlier.[2] The others received a prednisolone suspension (Hydeltra-T.B.A.).

The following patients are representative of this group. The duration of relief as of the patient's last personal follow-up visit is indicated.

Patient 1.—A 44-year-old electrician complained of "burning" right abdominal pain of several years duration. His only other symptoms were occasional "gas" and heartburn following a large meal or alcohol, promptly relieved by an antacid. Gastrointestinal x-rays and additional studies had been done one year previously. There

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*Brand of rapid and repository corticoid injectable (Schering).

was a history of an uneventful appendectomy at age 11. A localized area of exquisite tenderness was found adjacent and medial to the upper fourth of this scar; his presenting discomfort could be reproduced by pressure thereon. The complete blood count, urinalysis, fasting blood sugar, and bromsulphalein test were within normal limits. A single infiltration of the tender area with lidocaine and 1½ ml. Celestone Soluspan achieved dramatic and persistent relief. (Follow-up—26 months).

Patient 2.—A 52-year-old white female complained of longstanding discomfort in the lower abdomen. Part of her colon had been removed following an attack of diverticulitis one year prior to initial consultation. The incision had been made in the region of a previous operative (hysterectomy) site. A healed hypogastric vertical incision, with slight keloidal reaction, was noted. Exquisite tenderness could be elicited about 4 cm. above its inferior aspect. Subsequent barium enema and upper gastrointestinal x-rays were normal. The tender area was infiltrated with lidocaine and Celestone Soluspan, with prompt and persistent relief. (Follow-up—31 months).

Patient 3.—An 82-year-old white male was being attended for arteriosclerotic heart disease, malabsorption syndrome, recurrent diverticulitis, and laxative abuse. Although he fared relatively well on a conservative regimen, he continued to complain of persistent pain in the right umbilical and hypogastric areas. He had required emergency surgery five years previously for a gangrenous epiploic appendage. An exquisitely tender area within and medial to the incisional site was found. Pressure thereon reproduced his discomfort. Local infiltration with lidocaine and Hydeltra-T.B.A. afforded prompt and persistent relief. (Follow-up—19 months).

Patient 4.—A 62-year-old white female had been treated several years for recurrent and unexplained thrombophlebitis involving the upper and lower extremities. The condition was complicated by pulmonary embolism. Extensive studies performed at several institutions for a possible neoplastic, vascular or metabolic disorder failed to disclose such an underlying etiology. Anticoagulant therapy controlled the thromboembolic process satisfactorily. She also complained of considerable pain in the region of an extensive hypogastric incision, through which multiple operations had been done. They included an appendectomy, removal of a right ovarian cyst (1926), right salpingo-oophorectomy (1929), left partial oophorectomy (1931), cesarian section (1933), and resection of a partially obstructed colon (1940). A localized area of exquisite tenderness was found at the center of the scar. Infiltration with lidocaine and Hydeltra-T.B.A. achieved prompt and persistent benefit. (Follow-up—21 months).

The potential chronicity of incisional pain, already alluded to in the preceding case reports, is further illustrated by this patient.

Patient 5.—A 79-year-old thin white female had been attended intermittently for many disorders. These included osteoporosis, thrombophlebitis of the legs, malabsorption syndrome, respiratory and genitourinary infections, and several attacks of diverticulitis. During her follow-up visits, and in the absence of features indicating inflammation of the bowel or urinary bladder, she repeatedly complained of right lower abdominal and inguinal pain. Upper gastrointestinal and colon x-rays only were indicative of diverticulosis. A 50 year old appendectomy incision was then specifically examined and found to be exquisitely tender, primarily at its center. Moreover, her local and inguinal pain could be reproduced by pressure on this area. Infiltration with lidocaine and Hydeltra-T.B.A. afforded complete relief. (Follow-up—26 months).

Incomplete relief of abdominal pain, or its recurrence after initial benefit, may represent failure to infiltrate other painful trigger areas in or near the incision. For example, when repeated infiltrations failed to ameliorate the discomfort of Patient 7 completely, another tender area localized to the right rectus abdominis area was found that could be detected only when she raised her body slightly. By repeating the procedure in such a manner so as to place the infiltrating needle directly into the painful focus, complete benefit was achieved. The need for multiple infiltrations is exemplified by the following patients:

Patient 6.—A 63-year-old white female complained of longstanding intermittent hypogastric discomfort. A diagnosis of "chronic adhesions" had been rendered on the basis of her history of two prior operations (appendectomy and hysterectomy), repeatedly normal gastrointestinal, colon and genitourinary studies, and the lack of response to conventional "antispasmodic" and other symptomatic measures. Exquisite tenderness 3 cm. above the inferior end of the appendectomy incision (performed 13 years previously) was found. Local infiltration with lidocaine and Hydeltra-T.B.A. effected striking improvement. She returned one month later, primarily to ascertain the effect of salt restriction on recent hypertension. At that visit, she stated that the abdominal pain had recurred, albeit less intense than initially. Another area of exquisite tenderness was found about 1 cm. away from the previous site, and infiltrated in the same manner. Several weeks later, the patient spontaneously called to express her gratitude for the total freedom from abdominal pain achieved by these two procedures after a decade of suffering. For the first time in years, she was able to take nightly walks with her husband without distress. Although this patient manifested nonspecific gastrointestinal complaints the following year, the foregoing areas of tenderness were no longer demonstrable. (Follow-up—30 months).

Patient 7.—A 48-year-old white beautician initially was seen in consultation because of incapacitating narcolepsy and severe hypoglycemic attacks. She experienced prompt and prolonged benefit on a program of corrective diet and methylphenidate hydrochloride (Ritalin). Pelvic surgery was required several years later for a large ovarian cyst, which proved to be an endometrioma; no adjacent endometrial implants were noted. Severe abdominal discomfort persisted when seen four months postoperatively. Her tenderness appeared localized to the lower medial aspect of the incision, where a moderate keloidal reaction had developed. This area was infiltrated with lidocaine and Celestone Soluspan on 12-17-68.

Although she experienced considerable relief, she returned on 4-20-69 because the return of pain interfered with her work. Two tender nodular areas were identified at the superior aspect of the incision, and infiltrated in the conventional manner. Prompt benefit was obtained, enabling her to resume full-time work. She returned in one month, however, with a recurrence of pain in the same area. At that point, it was ascertained that the deeper right rectus abdominis structures had not been infiltrated adequately. When this was achieved (vide supra), considerable relief was forthcoming. Whenever she attempted to stand for prolonged periods at her work, however, she became aware of some abdominal discomfort. This was largely resolved by a change in occupation. (Follow-up—34 months).

Persistent incisional pain can develop shortly after laparotomy, and respond equally well to

local treatment. Two or more areas may require infiltration. The following patient is illustrative.

Patient 8.—A 35-year-old white laborer received injuries to his left chest and abdomen during an automobile accident. The spleen was traumatized, necessitating emergency splenectomy on 3-29-69. When seen in consultation on 5-2-69, his complaint centered about severe discomfort in the abdominal incision. It was greatest when he attempted to turn or to twist. He had been advised that little more other than "the effects of time" could help the pain. In addition to considerable keloid formation at the incisional site, three areas of exquisite tenderness were defined. They were infiltrated with lidocaine and Hydeltra-T.B.A., which afforded prompt and persistent relief. (Follow-up—3 months).

Abdominal Wall Pain Not Localized to an Incisional Site

Five additional patients with a similar sequence of events were encountered in whom chronic abdominal pain was present, but the tenderness localized elsewhere than the immediate area of an incisional scar. These sites included the rectus abdominis muscle, inferior costal margin, and insertion of the abdominal musculature onto the superior ramus of the pubis. (No evidence of osteitis pubis was present radiographically in the latter instances.) Comparable relief of their longstanding pain was afforded by one or several lidocaine-corticosteroid infiltrations. It is pointed out that the two patients (15 and 16) with rib tenderness complained of abdominal—not chest—discomfort.

Patient 13.—A 44-year-old white teacher was referred by her surgeon because of unexplained right upper abdominal pain that had resisted considerable treatment. There was some radiation of the pain to the back. Previous upper gastrointestinal, gallbladder and barium enema studies were unremarkable other than "some redundancy of the colon at the flexures." A number of diagnoses were considered, including peptic ulceration, hepatitis, pancreatitis, and biliary tract disease (in spite of normal cholecystograms). A pelvic ablation had been performed in 1963. She was re-hospitalized for evaluation of the abdominal pain, at which time careful gastrointestinal and gallbladder x-rays and numerous other studies were taken; all were within normal limits. She continued to complain of right upper abdominal discomfort during the ensuing 12 months. When specifically sought out, several areas of exquisite tenderness localized to the lateral aspect of the right rectus abdominis muscle were found. They were infiltrated with lidocaine and Celestone Soluspan on two occasions, with prolonged gratifying relief. (Follow-up—65 months).

Patient 14.—A 61-year-old white female had been attended by several physicians for diagnoses that included postmenopausal osteoporosis, asymmetry in length of the lower extremities, osteoarthritis of the back, and unqualified "pelvic pain." A benign polyp had been removed from the left vaginal fornix three years previously. An associated anxiety state responded well to psychiatric and supportive management. Thereafter, her main complaint was persistent discomfort localized to the left groin and left lower abdomen. Numerous studies at a teaching hospital within the preceding year failed to uncover the cause. An exquisitely tender area localized to the left superior ramus of the pubis was found. Pressure thereon reproduced her presenting abdominal pain. Infiltration with lidocaine and Celestone Soluspan promptly effected dramatic and persistent benefit. (Follow-up—22 months).

Patient 15.—A 67-year-old thin, white diabetic female had required insulin for 12 years. Her medical problem was complex, including an autonomic neuropathy, recurrent renal-tract infection, malabsorption, liver dysfunction, intermittent hyperthyroidism, and a history of renal lithiasis. She also complained of persistent hypogastric and lower abdominal discomfort that was not characteristic of intestinal, biliary tract or renal pain. Extensive laboratory and radiographic studies of the gastrointestinal tract, gallbladder and renal tract were within normal limits. On closer examination, it was found that pressure over a tender area on the superior pubis reproduced her discomfort. Local infiltration with lidocaine and Celestone Soluspan induced prompt and persistent benefit. (Follow-up—23 months).

Patient 16.—A 67-year-old black gardener had been treated for diabetes mellitus, essential hypertension, and a recent pneumonia. On several occasions, he complained of left upper abdominal pain which interfered with his ability to work. The discomfort lacked the usual burning component of a diabetic neuropathy and was not pleuritic in nature. Several tender areas over two left lower ribs were found, attributed to the severe cough during a respiratory infection; local pressure reproduced his discomfort. The ribs were infiltrated on several occasions with lidocaine and Celestone Soluspan or Hydeltra-T.B.A., which afforded virtual complete relief and enabled him to return to work. (Follow-up—24 months).

Patient 17.—A 42-year-old housewife sought consultation because of prolonged right upper quadrant pain. It began 15 years previously following the birth of her last child, at which time she felt "something tear" near the lower right ribs. Five sets of gastrointestinal and gallbladder x-rays had been ordered by several physicians; all were essentially normal. Her only gastrointestinal complaints consisted of infrequent mild heartburn and "gas." She specifically denied pleuritic discomfort. Tenderness localized to two areas over the inferior right rib and costal cartilage was found. Pressure thereon reproduced her upper abdominal pain. These areas were infiltrated with lidocaine and Celestone Soluspan. Although relief was achieved, the discomfort recurred a week later. Comparable infiltration of another trigger area, located 1.5 cm lateral to one of the earlier sites, afforded virtual complete relief. (Follow-up—6 months).

Discussion

The motif of this experience seemed so simple and "obvious" as it evolved that a formal report was delayed for years. As patients continued to be seen in consultation for such chronic abdominal discomfort due to unrecognized local tenderness, it became increasingly evident that (1) this entity is not so "obvious," and (2) it is infrequently taken into active diagnostic consideration by most internists, gastroenterologists and surgeons who are confronted with this problem. Indeed, the possibility of such an etiology apparently had not even been raised during prior consultation in any of the patients in this series. The dramatic response of their localized tenderness to the simple measure of local infiltration not only afforded

relief but considerably lightened both the diagnostic burden and implications. The latter ranged the gamut of abdominal malignancy, peritoneal or retroperitoneal fibrosis, connective tissue disorders, "abdominal epilepsy," mesenteric insufficiency, residual postoperative biliary-tract pathology, and psychophysiologic gastrointestinal reactions.

It is reasonable to attribute the etiology to some benign inflammatory process involving muscle, fascia, dermis, superficial nerve endings, or combinations thereof, since prompt amelioration was afforded by the pragmatic expedient of local anesthetic-steroid infiltration. Although contributory irritation from a wide belt buckle, tight-fitting corset, or torsion of these structures from habitual leg-crossing[3] may have existed in several patients, the pain persisted despite their interdiction until local therapy was employed.

Conclusion

A deliberate search for tenderness localized to the anterior abdominal wall, the lower ribs or superior pubis—particularly in or adjacent to incisional sites—should be routine when examining patients who present with unexplained chronic pain in the abdomen. The infiltration of such trigger points with a local anesthetic and corticosteroid preparation usually can provide prompt and permanent relief. My experience in 17 patients is reported. The pain was in or near an abdominal scar in 12 instances and at other areas in five. Such treatment also serves to minimize patient anguish and obviate needless radiographic studies and even diagnostic laparotomy.

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Now It's "Limousine Liberals for H.M.O.s"

Many advocates of health maintenance organizations are like limousine liberals—sending their kids to private schools while calling for public school integration. So says Robert J. Myers, Social Security's former chief actuary. None of the experts testifying for H.M.O.s at a Congressional hearing he attended were enrolled in prepaid groups, though Washington, D.C., has good ones.

Some Unusual Complement Fixation Responses in Narcotic Addicts

A Preliminary Report

Ernest C. Miller, M.D., Simon D. Doff, M.D.,
Stanley Music, M.D. and Elsie E. Buff

Abstract: Sera from 33 to 35 ex-heroin addicts showed a positive complement fixing reaction to antigen for lymphogranuloma venereum. Sera from six of them randomly selected exhibited further positive complement fixing response to water soluble antigen cultivated on embryonated eggs. A variety of other antigens failed to fix complement. The complement fixing reaction of sera from the ex-addicts suggests the possibility of a relatively simple, rapid, serologic screening test for heroin addiction.

A variety of serologic abnormalities in narcotics addicts has been reported in the past four years. These include atypical febrile agglutination responses,[1] biologically false positive tests for syphilis,[2] persistent transaminase elevations,[3] increased M-type immunoglobulin,[4] and increased opsonic capacity.[5] In 1968 Cherubin and Millian[6] reported an increased reactivity in complement fixation tests for lymphogranuloma venereum and Q fever.

Positive complement fixation reaction to lymphogranuloma venereum-psittacosis antigen (LGV) was reported for heroin addicts enrolled in the Methadone Maintenance Program in Jacksonville. We pondered the possible relationships with reported serologic abnormalities. This study was initiated to determine if a serologic pattern could be identified in an addict population utilizing several specific complement fixing procedures.

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Dr. Music is assistant epidemiologist, Bureau of Preventable Diseases, and Miss Buff chief virologist, Bureau of Laboratories, Florida Division of Health, Jacksonville.

Materials and Methods

The 35 patients included in the study had not been off heroin for more than two weeks. Twenty-four initiated addiction locally, six in New York, one each in Ohio and Pennsylvania, two in Viet Nam and one in Korea. One utilized nasal insufflation; the remainder administered the drug intravenously. Prior to admission to the Program 24% used less than five bags of heroin per day and the remainder from five to ten. The average duration of addiction was about three years.

The patients ranged in age from 18 to 59 years with 85% in the 20 to 30 age group. Approximately 75% were male with a 4:3 ratio black to white. Eight had infectious hepatitis during the addiction period and three of these acquired the disease within two years of admission to the Program. Eight reported having, or having been treated for, gonorrhea and one for syphilis.

Sera were obtained and examined by the Virus Unit, Bureau of Laboratories, Florida Division of Health, using the micro technique[7] and LGV-psittacosis antigen prepared by the Communicable Disease Center in Atlanta. Sera from six patients were selected randomly and subjected to a battery of complement fixing procedures including influenza A, influenza B, normal membrane control (embryonated eggs without antigen), adenovirus, tissue control, California encephalitis, normal mouse brain and commercial psittacosis antigen.

Results

Only two of the 35 patients exhibited negative reactivity (less than 1:8) to the LGV-psittacosis antigen. One patient exhibited a titre of 1:256 and approximately 70% exhibited titres of 1:8 or 1:16, with approximately an equal number of patients in each category.

Responses of the six selected patients are reported in Table 1. Complement fixation tests represented in columns A, B and C utilized water soluble antigens cultivated on embryonated egg. These produced consistently positive results. Test shown in column D utilizing normal membrane control yielded no positives, and complement fixation tests for adenovirus, adenocarcinoma, California encephalitis (La Crosse strain) and normal mouse brain were consistently negative except for one departure in patient four (adenovirus). Complement fixation tests with commercial psittacosis antigen were also uniformly negative. Antigens for columns E through H were not water soluble or derived from embryonated eggs.

Discussion

These results suggest that serum from ex-heroin addicts produces positive results in complement fixation tests utilizing water soluble antigens derived from embryonated eggs. This knowledge has not been previously reported in the medical literature.

Review of Division of Health laboratory records for 1968-1971 reveals that approximately 100 LGV complement fixation tests were performed with only 3% positive results. As only limited data were available these patients could not be matched for age, sex, race, sexual habits and other variables with the population reported in this study.

Cherubin and Millian[6] found about 28% of an addict population to exhibit positive responses to LGV complement fixation, which is low in comparison to our 94%. They do not specify the type antigen used and a crucial difference may obtain from this. Commercially prepared antigen produces a low yield.

Vogel and his associates[1] state that the non-specific reactivity of addicts' sera makes any diagnosis based on these tests open to question. Among various theories explaining the unusual serum reactivity and composition have been the suggestion that addicts by hygienic improprieties during intravenous administration of their drug subject themselves to multiple extraneous antigens and a variety of infections. Another is that many of them harbor subclinical hepatitis. These theories, however, do not explain specifically the differential reaction to complement fixation tests utilizing water soluble antigen derived from embryonated eggs as opposed to other types of antigen.

The group of addicts studied here were widely dispersed geographically at the time of birth and of initiation of their habit. Such mitigates against regional adulterants in the purchased heroin as contributing to the demonstrated peculiar immune state. It also tends to lessen the prospect of other regional geographical factors being involved.

Methadone appears to have been ruled out as a common association with the positive test as seven of the group produced positive LGV titres prior to admission to the Methadone Maintenance Program. When reported positive 26 of the patients had been enrolled in the Program for less than two weeks. No correlation was found between the magnitude of the LGV, influenza A or influenza B titres and the reported duration of the habit nor with the daily amount of heroin used by the addict during his addictive phase.

TABLE 1.—RESULTS OBTAINED FROM COMPLEMENT FIXATION METHODS ON SIX EX-HEROIN ADDICTS.

Patient	A* LGV-Psit.	B Inf. A	C Inf. B	D N/C Am	E Adeno	F Ic	G CE (LAC)	H NMB	I Psit (Com)
1	1:16	1:16	1:32	<1:8	<1:8	<1:8	<1:8	<1:8	<1:8
2	1:8	1:8	1:16	<1:8	<1:8	<1:8	<1:8	<1:8	<1:8
3	1:8	1:8	1:8	<1:8	<1:8	<1:8	<1:8	<1:8	<1:8
4	1:32	1:8	1:8	<1:8	1:32	<1:8	<1:8	<1:8	<1:8
5	1:32	1:8	1:16	<1:8	<1:8	<1:8	<1:8	<1:8	<1:8
6	1:16	1:16	1:16	<1:8	<1:8	<1:8	<1:8	<1:8	<1:8

*A—Lymphogranuloma venereum—psittacosis
B—Influenza A
C—Influenza B
D—Normal membrane control—embryonated eggs
E—Adenovirus
F—Tissue control, malignant cells for adenocarcinoma test
G—California encephalitis (La Crosse strain)
H—Normal mouse brain
I—Commercial psittacosis antigen

The pattern of these complement fixation responses is intriguing but biologically mysterious and whether the findings can be replicated in other addict populations remains to be seen. In view of the important diagnostic implications, further studies are under way in an attempt to identify and characterize a particular antibody and a more specific antigen which might account for these apparent biologically false positive reactions.

Acknowledgment

We thank Ralph B. Hogan, M.D., Florida Division of Health, Jacksonville, for his helpful suggestions.

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Dr. Miller, Department of Psychiatry, University Hospital, Jacksonville 32203.

Below is a letter received by M. Harlan Johnston, M.D., President of the Duval County Medical Society. It speaks for itself.

Dear Doctor:

This is an open letter to the members of the medical society about the treatment of a condition that I never recall having seen in a textbook but that many physicians are called upon to treat —that is, grief.

Two weeks ago a friend of ours lost his 57 year old mother—she died at home from cancer. It was on a Saturday night and when her death was obviously imminent the family called their physician. The man who was on call regretted that there was nothing he could do and declined to come. A friend, who is also a physician, *did* arrive, just as she died. When our friend told us this story I recalled my 79 year old father's death last year and the callousness with which we were treated by one physician on call, as well as the kindness which we received from another.

I am sure that all of us feel inadequate in the face of death and particularly physicians who are committed to preserving life. I am also aware that each man is endowed differently with the personal strength to deal with situations in which he cannot be successful. But this letter is a bid to all physicians to turn to a situation in which they cannot help but succeed—that is the treatment of grief. The family surrounding the patient is a part of the body of that patient and their care is, I'm sure, part of the concern of the modern physician.

To all of you who have cared for and comforted the many families you have inherited at a death bed, I send my deepest admiration and respect. And to those of you who have found this task too difficult I send my sincerest understanding and compassion and my prayers that you will find the strength next time.

Most sincerely,
Mrs. B. K., R.N.

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On Pulmonary Thromboembolism

Manuel Viamonte Jr., M.D.

Abstract: Pulmonary thromboembolism is a frequent, often misdiagnosed, potentially fatal, occurrence. Cardiovascular decompensation may obscure this process. The protean clinicoradiographic manifestations depend on the location, extent, acuteness and nature of the disease; on the status of the underlying lung, and on the adequacy and promptness of its resolution. Pulmonary perfusion scan should almost always precede pulmonary angiography, and may advise against it. Catheter-angiographic studies are the definitive diagnostic tests but should not be undertaken indiscriminately. We consider the search for a source an essential aspect of the radiologic examination.

The various radiographic findings of the pulmonary thromboembolism syndrome depend on the location, extent, acuteness and nature of the thromboembolic process; on the hemodynamic and ventilatory pre- and postembolic status of the lungs, and on the adequacy and promptness of the resolution process.

Central occlusions are characterized radiographically by focal hyperlucency with or without centrally enlarged pulmonary arteries. Preinfarction is manifested by regional interstitial changes (reticulolinear pattern; perivascular haziness) secondary, probably, to interstitial edema and/or hemorrhage. We have observed that focal reticulation is followed either by complete resolution or by the development of overt infarction. Pulmonary infarction is expressed by nonspecific, ill-defined, shapeless, discrete, usually homogenous opacities, usually in the lung bases and indistinguishable from areas of edema, pneumonia, or other alveolar processes. The frequent involvement of the pleural surface of the lung elicits a pleural reaction in the form of effusion. The infarction (physiopathologically congestive atelectasis) is associated usually with evidence of loss of volume. In the other lobes, this is characterized by elevation of the homolateral hemidiaphragm; in the right lung, by downward displacement of the minor fissure (usually equidistant between clavicle and dome of the right hemidiaphragm). Often discoid atelectasis is the only manifestation of thromboembolism.

Most emboli resolve without infarction (about 90%). Infarctions may resolve, cavitate, or be followed by a scar. Emboli may calcify.

Recurrent, multiple, pulmonary thromboembolism may lead to the syndrome of precapillary pulmonary arterial hypertension. In such a situation disproportionate enlargement of the central pulmonary arteries contrasts with diminished peripheral vasculature. Variable degrees of convexity of the middle arch of the left heart border (from dilation of the pulmonary trunk) are observed. The heart is not enlarged usually, unless there is coexistent heart disease.

Radioisotopic imaging techniques (pulmonary perfusion lung scans) should precede the angiographic evaluation because of their usefulness in selecting patients for angiography. Usually in the presence of a normal pulmonary scan angiography is unwarranted. The lung scan is the simplest, safest, most informative radiologic technique for evaluating the anatomic progression or regression of the pathological process (by repeating the study during the course of treatment). Ventilatory pulmonary scans usually correlate with the perfusion scan (normal ventilation with abnormal perfusion). However, in instances where consolidation of the lung is observed radiograph-

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ically, (infarction), both perfusion and ventilation are abnormal at the involved area. In the presence of a nonspecific pulmonary opacity, if the scan shows perfusion defects in areas apparently uninvolved radiographically, thromboembolism is the usual diagnosis. In emphysema the perfusion and ventilatory scans are both usually abnormal. In uncomplicated thromboembolic disease (hyperlucency without infarction) the ventilatory scan is usually normal at the site where the hyperlucent area is observed radiographically. However, in infarcted areas, the ventilatory and perfusion scan are abnormal.

Pulmonary angiography is recommended in the following situations: massive or submassive pulmonary thrombolism, particularly if the patient is considered for surgery; recurrent pulmonary thromboembolism in a patient on anticoagulant therapy; in patients with the so-called idiopathic pulmonary arterial hypertension; and when there are unexplained, persistent, radiographic pulmonary abnormalities and infarction is suspected.

Vascular catheterization allows for pressure recordings from the right heart chambers and pulmonary trunk, for selective injection of radiopaque contrast medium, tailored to the extensiveness of the process and for the opportunity for retrograde study of the inferior vena cava, pelvic, and ovarian veins (if clinical condition of patient permits). In acutely ill patients, partial cardiopulmonary bypass should precede the angiographic examination.

When patients have a history of atrial fibrillation, other arrythmias or congestive heart failure, and where there is no history of a possible abdominal, pelvic, or extremity venous pathology, the source of emboli may be the right side of the heart. In these situations, the first angiographic study should be done with the catheter in either vena cava and with the patient lying in the prone right anterior oblique position. Rapid filming is essential in order to depict the segmental filling of the right heart chambers, and special attention should be given to the region of the right auricular appendage. This structure is in a dependent position when the patient lies prone and if it fails to opacify or contains filling defects, the heart should be considered as the source of emboli. If the source of thromboemboli is not found in the right side of the heart, ascending venography of the lower extremities, pelvic venography, cavography and gonadal venography should be done routinely. Disappointingly, in many instances, a source of thromboemboli is not found.

Selective bronchial arteriography may demonstrate collateral circulation to the lung, particularly in instances where central branches of the pulmonary artery have become occluded.

Differential diagnosis of pulmonary thromboembolism include: in children, pulmonary branch stenosis, and in adults, pulmonary emphysema, arteritis, and any conditions in which abnormal opacities of the pulmonary parenchyma are observed.

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ALL ABOUT LOVE. In my practice at the Atlanta Psychiatric Clinic people sometimes ask me what this psychiatric stuff is all about. It's increasingly clear to me that almost all emotional problems could be summed up in one particular bit of behavior—it's a person walking around screaming, "For God's sake, love me." Love me, that's all. He goes through a million different manipulations to get somebody to love him.

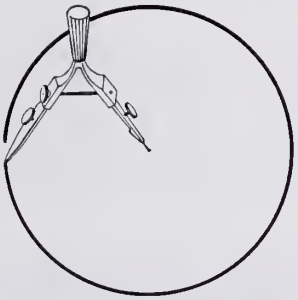
And that's the core of most emotional sickness.

The healthy people are walking around looking for someone to love. And if you see changes in the people who are screaming, "Love me, love me," it's when they realize that if they give up this screaming and go to the other business of loving another human, they can get the love they've been screaming for all their lives. It's hard to learn, but it's good when you learn it.

Thomas P. Malone, M.D.
Atlanta, Georgia

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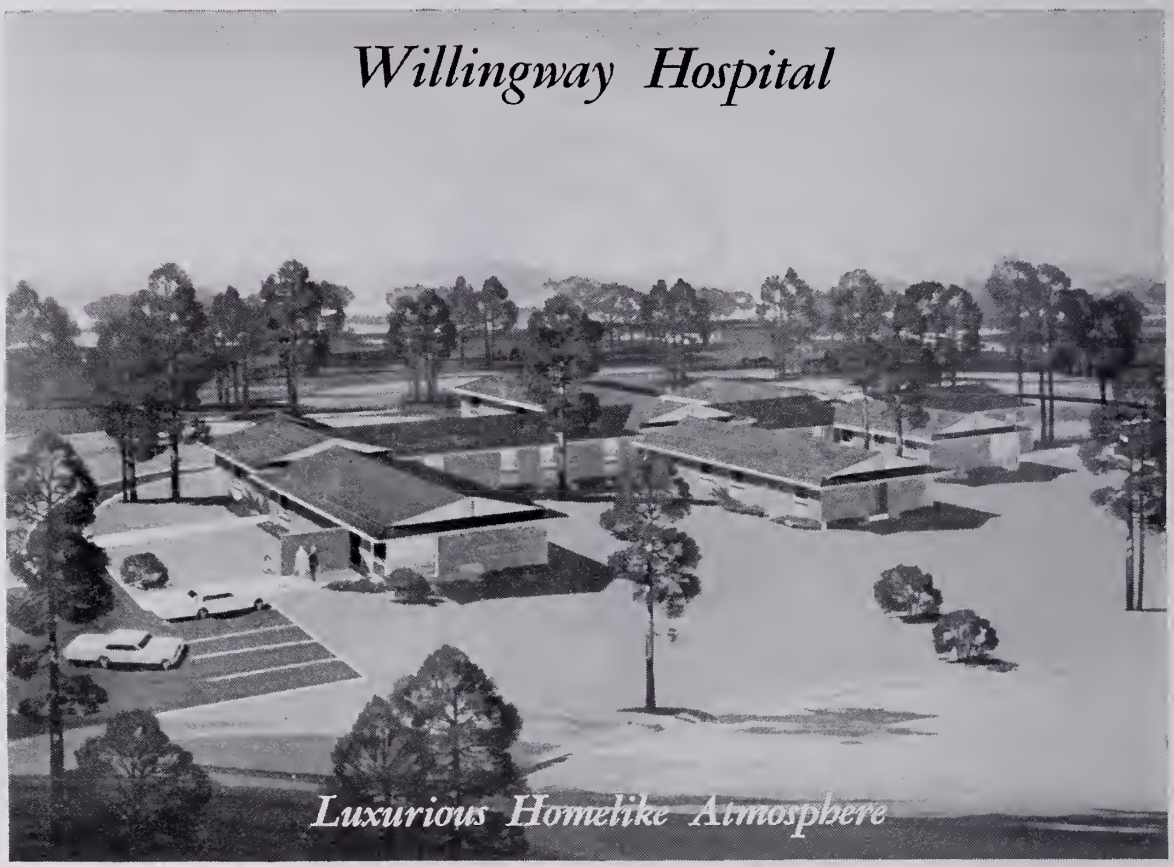
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Special Articles

The Impact of Legalized Abortion Laws on Private Practice

W. Otis Duck, M.D.

In medical school we were taught altogether along the lines of the preservation of life, so the recently enacted abortion laws have the impact of provoking serious considerations, pro and con, concerning this important problem in our society. Each practicing physician has his own conscience and attitudes which may be tempered from time to time and in varying degrees by the passage of new laws, sociologic pressures and demographic projections. The assumption that obstetrician-gynecologists would readily jump on the bandwagon and perform abortions when the law changed may not necessarily be true. They usually enter their specialty with a primary objective of delivering babies.

Dr. Eugene Diamond, Professor of Pediatrics at Loyola University, philosophically projects the feeling that the new abortion laws may be too liberal. He states, "One of the uninsurable risks of medical practice is that sometimes we begin to believe in the fantasies of our patients. Though patients may ascribe God-like qualities to us, I doubt seriously if they approve of our acting them out. No abortion is ever performed on 'amorphous cell masses' or on 'blobs of protoplasm' as some abortion proponents have suggested. Most abortions are performed between the 8th and 12th week of pregnancy, and by then all fetal organ systems are present and functioning, including the nervous system." Dr. Diamond says that the 12-weeks fetus can indeed feel the pain from the curette. He points out that most states recognize that the unborn child does have rights under the law. A mother can sue for the support of her unborn child, or hold a defendant liable for injuries sustained by her unborn child as a result of accident or assault.

Presented at the Florida Medical Association Rhine Passage Seminar, April 14, 1972.

Incidence

The rapid increase, however, in legal abortions in the United States from about 6,000 in 1966 to more than 400,000 in 1971 attests to the growing popularity and acceptance of the operation as a legitimate medical procedure. Since 1966, 17 states have liberalized their laws concerning abortions, and almost all other states have pending legislation under consideration.

During the past year more legal abortions have been performed in the state of New York than in any Scandanavian country over a period of three decades, or in the whole of Britain since implementation of the 1967 Abortion Act. The proportion of unmarried women receiving legal abortions in the United States is higher than that in any other country.

The ratio of legal abortions to deliveries is currently 10/100 or higher in 20 states in the eastern United States, perhaps largely attributable to women traveling from these states to New York for the operation.

The projected abortion rate for New York City residents is approximately 400 per 1,000 live births during the year 1972.

In North Carolina (69 hospitals reporting) these data seem to reflect the trend as to the number of therapeutic abortions performed:

1967 (June to December)	72
1968	146
1969	311
1970	1,293

The experience in our own hospital in Asheville, N. C., revealed that in 1966 we had three therapeutic abortions, in 1967 (the year our present law was enacted) 10 were done, in 1968 we had 11, in 1969 there were 13, in 1970 a total of 68 were performed and in 1971 the number

rose to 142. The ratio of therapeutic abortions to live births within our hospital was 8.3 per 100 deliveries. In 1970 reasons for therapeutic abortions listed in North Carolina were psychiatric 88%, medical 10.5%, rape or incest 0.7%, and fetal indications 0.9%.

Morbidity

The death rate in the United States computed by the Joint Program for the Study of Abortions in 1970-71 was reported to be 8 per 100,000 abortions. In recent years England's reported rate has been 25 per 100,000; Sweden's 18 per 100,000; Czechoslovakia's 2 per 100,000; and Hungary's 1 per 100,000. These differences surely reflect varying proportions of early and late abortions. Of course the countries with the lowest rates would be considered to have had the highest percentage of early abortions done.

Dr. Maria Perez-Reyes, of the division of child psychiatry at the University of North Carolina, states that transient feelings of guilt, worry and depression following therapeutic abortion were reported by about half of a series of adolescent girls. However, she stated that the crying spells, angry feelings and depression were primarily confined to the immediate postoperative period. Only one of a series of 22 girls available for five months follow-up expressed regret at having had the operation.

In a California study done in San Francisco in 1969-70 it was reported that in girls under 18 years of age a great deal of ambivalence and guilt were encountered.

Laws

The following gives one some idea as to the general provisions of some abortion laws now in existence:

North Carolina—Abortion may be performed (1) In cases of rape or incest, if the act is reported to law officials within seven days; (2) Consultation must establish that there is a definite potential hazard to the health of the mother, or a probable deformity or mental defect of the infant; (3) The mother must have resided in the state four months; (4) The mother (or parents in case of a minor) has to give written consent for the operation; (5) The hospital must be licensed by the North Carolina Hospital Care Commission; (6) Certification must be filed with the hospital as to necessity.

British Abortion Law of 1967—Essentially the same as North Carolina law except that it does include a clause which would reasonably expect the continuation of the pregnancy to affect the physical or mental health of existing child or children in the family.

Colorado—Similar to North Carolina law, but mentions no residency requirement, and does require action from a special hospital board of three physicians in addition to the patient's own doctor.

California—Similar to North Carolina law, but it omits any fetal indications.

New York—Involves only the pregnant woman and the physician. Abortion may be performed on demand up to 24 weeks gestation.

Indications

A review of the records of a Delaware hospital's 634 therapeutic abortions in 1969-70 by Dr. Oscar Stern revealed that 609 were done apparently for socioeconomic reasons, though they had been certified by psychiatrists as therapeutically necessary. "Transient situational disturbances" was listed as one of the major psychiatric reasons for therapeutic abortion in a series at the University of North Carolina. The average mean age there was 24.2 years.

Studies reviewed throughout the literature during the past three years would cause one to conclude that in the medical and social dilemma created by the enactment of more liberal laws, psychiatric labels frequently mask humanitarian or sociologic reasons for abortions.

Physician Responsibility: Sociology

Perhaps ideally there should be reasonably uniform law in all states which would not only provide for all residents to have adequate technical skill for the actual performance of the operation within suitable facilities, but the patients should be entitled to a program of rehabilitation of the individual through the use of trained counselors, in order to at least minimize repetition of additional unwanted pregnancies.

We, as physicians, must assume a greater role in effecting a more efficient educational program through planned parenthood endeavors, sex education in schools, and explore any other avenues

which may tend to minimize the number of unwanted pregnancies. Sound professional medical judgment must be exercised in much the same way as for any other medical or surgical procedure. A thorough study of the pregnant woman's request for an abortion should be made in an effort to learn why the request is made, and whether there can be reasonable scientific justification for doing the procedure.

It would seem appropriate for physicians in any state contemplating passage of legislation legalizing therapeutic abortion to evaluate their total facilities, with special emphasis being placed upon adequately prepared personnel to be involved with effective peri-abortal care, including counseling.

No woman should any longer have to undergo a criminal abortion. Even if the laws in her state will not permit legal therapeutic abortion, she can easily be referred to another state where a safe procedure can reasonably be expected to be performed.

Contraception is available, effective and by far the most logical method of birth control. In theory, at least, couples should voluntarily employ some method of contraception, lest we be eventually faced with some form of compulsory birth control measures in order to prevent ultimate overpopulation of the earth. Education in the area of human sexuality should be begun in appropriate form for males and females in kindergarten and continued throughout all their school years.

As we observe society's attempts to handle the problems of demography, it would seem in every instance that the physician is considered the common denominator. However, therapeutic abortion is now as much a social and legal issue as it is a medical one.

Experience in Sweden has shown that even the passage of a liberal abortion law has not stopped criminal abortions. Only time will tell what the effects of liberalizing the laws will have on criminal abortions in our country. In America the impact of legalized abortion laws will perhaps soon make the process of adoption close to impossible.

The impact of legalized abortion laws on hospital beds and physician time seems in many places to be jolting. In many teaching hospitals, particularly in New York, the house staffs want no part of abortions. Many say it would ruin their residencies.

The experience in New York showed that during the first few months after the law was liberalized there was considerable turmoil, and a noticeable shortage of beds for the sick. It would appear that the law was passed with exceeding haste, and without desirable planning which could have eliminated many problems, especially in the realm of logistics.

Conclusion

Therapeutic abortion has probably been one of the most written about single subjects in American medical literature during the past three years. I have made an effort to review some of the facts which directly or indirectly relate to the impact of liberalization of the abortion laws on the practice of medicine. I do not believe anybody has all the answers, and nobody's theory must necessarily be considered all right or all wrong. The meaning of the law, the physician's scientific evaluation, along with judgment sufficient to sustain his own conscience would seem to in some measure gauge the impact of legal abortions on the practitioner. To quote from ACOG 1971: "The unmarried female of any age, whose sexual behavior exposes her to possible conception, should have access to the most effective methods of contraception."

▶ Dr. Duck, Community Medical Center, Mars Hill, N. C. 28754.

Best way to forget about the high cost of living is to live so that life is worth more.

Private Health Delivery: Dare We Junk It?

Vernon B. Astler, M.D.

Abstract: We read and hear a great deal today about the "health crisis," infant mortality, pros and cons of the free enterprise medical system, the doctor shortage, the unconscionable income of physicians and the high cost of health care. As a representative of the private sector of health delivery, I would like to explore various allegations that have arisen concerning these topics.

Let us first agree, however, that we must endeavor to seek solutions for specific problems of specific populations and not destroy good working systems now serving the majority of our citizens well.

Recently the editorial pages of both *The New York Times* and *The Chicago Tribune* have stated that "the case for a national health care crisis is contrived at best." I agree. I am aware of, and deplore, specific instances of patients frustrated by inability to find a doctor, or instances of ineptitude, indifference, or apparent avarice. Our profession is dedicated to correct these deficiencies and transgressions. So far as the system is concerned, however, consider its strength. How does it *usually* respond? At this very minute a million or more people are being ministered to directly in doctors offices, clinics, hospitals, diagnostic and treatment centers all over this country.[7] The median American life expectancy is now almost 75 years and increases progressively. Since 1920, life expectancy has increased 13 years for males and 20 years for females.

Even the frequently lamented data on infant mortality show a current rate one-sixth of that 50 years ago, down 7.7% this past year alone. In some states infant mortality is now barely over 14 per thousand live births. Some data for specific populations are not good. Though improving, infant mortality in some black communities exceeds that of the national average by 30 to 50%. One might logically ask why. This surely relates in some way to poverty, poor nutrition, or inaccessibility to prenatal care. However, some indepth studies correlate this excessive infant mortality primarily with the level of education achieved by the mother. An indictment of our educational system perhaps, and not the health care system.[7]

Let us consider our free enterprise system and how it has changed. Infectious disease mortality has been altered dramatically. In 1968, deaths from communicable diseases were 18% of 1930, and 30% less than 1950. Polio, diphtheria, tuberculosis, and tetanus were diseases that struck fear into the hearts of families for years. Today, they have virtually been wiped out. The same might be said for septicemia, spinal meningitis, strep throat, impetigo, and mastoid infections. Vaccines are available for measles, polio, diphtheria, tetanus, smallpox, cholera, typhoid fever and many others. Antibiotics have been developed to alter significantly most of these fearful infectious diseases. Cancer research continues and breakthroughs are occurring almost daily—breakthroughs which serve to increase the quality as well as the quantity of life.

Operative mortality has decreased remarkably since the 1950's. Mortality for removal of the gallbladder since the 1950's has dropped from 3% to 0.5%. Mortality for lung resection in the same period from 4 or 5% to less than 1%. Operations have increased in scope and quality. Organ transplants have developed and medical technology has boomed. Kidney transplants from well-matched living donors can expect a long term survival of 85 to 90%. Cadaveric grafts will give a long term survival of 50 to 60%. These are quite acceptable figures when the alternative is considered.[3] One must recall in the past two decades, we have developed cardiac pacemakers, oscilloscopes, artificial heart-lung machines, cryosurgery, electrosurgery, prosthetic materials for arteries, filters and screens for vein surgery, highly refined feeding apparatus for intravenous feedings, nasogastric feedings, suction pumps, air mattresses, ice mattresses, electric beds and lifts, fiberoptic flexible endoscopes, artificial hearts and many other developments too numerous to enumerate. This is your

Presented at a seminar on Improving the Delivery of Health Services sponsored by the Bureau of Comprehensive Health Planning, West Palm Beach, Florida, May 3-6, 1972.

Dr. Astler, President of the Florida State Board of Medical Examiners, and Chairman, FMA Council on Medical Economics, is engaged in the private practice of surgery at Boynton Beach, Florida.

system of free enterprise medical care and how it is delivered.

We hear of the doctor shortage. Let us consider it and what the health care system has done in this regard. As of December 31, 1970, there were 334,028 medical doctors in the United States of whom 311,000 were actively involved in the practice of medicine. In 1960, there were 140 physicians per 100,000 population compared to 158 physicians per 100,000 population in 1970. In other words, there was one physician for 712 people in 1960 compared to one physician for 632 people in 1970. In 1968, approximately 3,700,000 persons were employed in the health fields in the United States. A total of 7,144 hospitals with 1,649,663 beds were serving the U. S. population in 1969. Of these, 5,853 were community hospitals. In addition, there were 19,141 nursing homes with 836,554 beds. The average stay in community hospitals in 1969 was 8.3 days; the average occupancy rate was 79%. Hospital utilization has gone up in community hospitals from 1950 to 1969.

Let us consider our State. Florida has suffered an undeserved reputation that physicians are kept out by the Florida State Board of Medical Examiners through intellectually grueling examinations. The record indicates that the number of physicians passing Florida exams in the previous three years are as follows: 1969—951 M.D.'s were licensed; 1970—1,759; 1971—2,095, for a total of 4,805 physicians licensed in Florida in the past three years. Only New York and California license more physicians yearly than does the State of Florida. I might add that foreign graduates make up a larger percentage of failures than physicians educated in the United States. The wheels are turning to educate and deliver more physicians, and we have in this State a new medical school in Tampa offering a three-year program of 36 months of continuous training to graduate doctors in three instead of four years. At the University of Florida a program accepting the first two years of medical education from affiliated universities is under way which allows more third and fourth-year students at the school of medicine. Preliminary work is done at Florida State University and other affiliated schools. At the University of Miami, there is a program allowing Ph.D.'s in the human sciences to be admitted to the third year of medical school provided they are qualified and meet the acceptance standards. Another adjunctive measure implemented by the private sector in the State of Florida is the physician's assistants program. To date, 28 schools have been approved for a 24 months program. The Florida State Board of Medical Examiners is charged with the obligation of approving these schools and protecting quality over quantity in introducing these individuals into the medical field. These physician's assistants should serve greatly to extend the physicians arms in health delivery.

Nationally, the doctor shortage is being alleviated. First-year United States medical school enrollments have increased for five straight years and for 15 of the last 16 years. Total enrollment in all medical school classes rose 2,818 in 1970-71 for a total of 40,487 medical students. In the year 1971-72, first year medical school enrollment rose to 12,150. Two new medical schools admitted their first students for the 1970-71 school year and five more did so this year bringing the total medical schools to 108 with five more expected to open next year. At the same time the number of fulltime faculty members rose to 26,577; this allows a ratio of 3.7 students per faculty member. Eight years ago there were only 14,468 fulltime faculty members in medical schools with a student-faculty ratio of 4.9 to one. Minority enrollment is increasing. In 1968-69 black students made up 1.4% of total first year enrollment excluding the predominantly black schools of Howard, Meharry and the University of Puerto Rico. In 1970-71 blacks made up 5.3% of the first year classes.

While admittedly in need of continued improvement, the much maligned system in this country does serve the majority of Americans well. I might add that of all institutions and professions, only medicine today evokes a vote of confidence from the majority of the public. A recent poll revealed that more than 60% of Americans expressed substantial confidence in medicine while fewer than one third have similar confidence in organized labor, advertising, news media, government or even organized religion.

Before I leave the subject of physicians, I would like to say a word about physicians' fees. A recent article in *The New York Times* criticized the average income of physicians. This has been estimated by *Medical Economics* to be $40,000 a year and by AMA figures to average $35,000 a year. The figures reveal that the average weekly net earnings of a physician are approximately $775 and their average work week is approximately 60 hours. Their per hours earnings are,

therefore, $12.92. In the Detroit area, brick layers averages $10.36 per hour, electricians $10.62 per hour, and plumbers $10.28 per hour. If an electrician works 60 hours a week with double time past 40 hours, he would earn $44,179 per year. Economically, we are holding our own. To this we must add that in 1969 Americans spent $16.4 billion on alcoholic beverages, $10.2 billion on tobacco for a total of $26.6 billion. In 1971, $14.2 billion was spent for physicians' services and since 1965, physicians services as a per cent of total health care expenditures has decreased from 21.5% to 18.9% in 1971.

What about private health insurance? In 1970, 181.5 million Americans or more than 89% of the civilian resident population were protected by one or more forms of private health insurance. The number of persons under insurance company plans has increased 47% between 1960 and 1970. The number of persons having surgical expense insurance reached 169 million by the end of 1970, a 44% growth over the past decade.

Two key words dominating the successful operation of our system are *access and mainstream*. Many people lack *access* to the *mainstream* health care either from a lack of education or lack of personal initiative to seek it. Here, greater emphasis on health care education is needed. Others lack *access* to *mainstream* health care because of geography or cost. The problems of rural care are substantial but ought to be dealt with separately. The numbers of people are small and the geography vast. Fewer than 3% of the population reside more than 20 miles from some medical facility. It is likely that a transportation system has more to offer these people than redistribution of medical personnel or facilities.[7]

Lastly, means need to be devised to provide access to health care for that 10 to 15% for whom the barrier currently is cost. In this regard several points need emphasis. First, there is no question that reducing financial barriers to obtaining medical care results in the delivery of more and better health care services, and a better quality to more people. Second, it is possible to provide mainstream health care to most disadvantaged people by introducing them into it. It is not necessary to move the mainstream. Third, the sharp contrast between the implementation of Title XVIII and Title XIX in most states should demonstrate amply that the direct administration of a totally free program of medical care by government agencies inevitably produces both astronomical costs and second-class care. In California, Title XIX covering 1% of the national population now costs $1.5 billion. Simple arithmetic suggests that expansion to the entire population of the United States would require $150 billion annually![7]

In summary, I would say that as Americans we have access to the finest medical care in the world. Our system of essentially private practice has its failings, to be sure, but it is infinitely superior to the state-supported schemes of Europe. As defenders, physicians are forever on the defensive and the posture is unappealing. The medical profession has little time or opportunity for telling the story of doctors who gave an estimated $600 million in free medical care in the past year; of doctors who worked longer hours and harder than most Americans, and who have given themselves to public service and who often earn less after taxes than plumbers, politicians, or actors. We are dedicated to correct the inequities in our system.

I would say that at a time when our government is experimenting with wage and price controls, attempting to bring about a realignment of the dollar and a basic change in the international monetary system, and running a $25 to $35 billion deficit annually, it would be foolhardy to embark on a major overhaul of the health care system which *is* delivering. Changes in the health field should be made, to be sure, but they should be made slowly and carefully without jeopardizing a known system of delivery which continues to make progress.

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The Medical Examiners Act — A Giant Step Forward

James E. Fulghum, M.D., Joseph H. Davis, M.D. and James Hinson

The Medical Examiners Act of 1970, Chapter 406, Florida Statutes, when fully implemented, will provide a much needed uniform Medical Examiner service throughout the State. The members of the Medical Examiner's Commission are appointed by the Secretary, Health and Rehabilitative Services and consist of two pathologists, one funeral director, one state attorney, one representative of the Office of the Attorney General and one from the Office of the Department of Law Enforcement.

The Medical Examiner's Commission is empowered to create Medical Examiner Districts which has been done; nominate District Medical Examiners, and to promulgate rules. The District Medical Examiners are appointed by the Governor of the State.

The duties of the District Medical Examiners are to perform or have performed any examinations, investigation and/or autopsies necessary to determine cause of death:

1. When any person dies in the State:
 a. Of violence, homicide, suicide or accident
 b. Suddenly, when in apparent good health
 c. When unattended by a practicing physician or other practitioner
 d. In police custody, prison or penal institution
 e. In any suspicious or unusual circumstance
 f. By poison, criminal abortion or by disease constituting a threat to public health, or
 g. By disease, injury, or toxic agent resulting from employment
2. When a dead body is brought into the State without proper medical certification, or when a body is to be cremated, dissected, or buried at sea
3. Report findings to State Attorney and/or County Solicitor.

In view of the implementation of Article V and the abolishment of the Justice of Peace—Coroner System, there is an increasing and urgent need for a uniform statewide Medical Examiner's system.

Chapter 406, Florida Statutes also paves the way for careful and adequate medicolegal death investigation and is specifically worded so as to provide the State of Florida with sound factual information as to the prevalence of alcohol and drug abuse in the causation of death, the human factors which result in fatal accidents and the disease processes which strike down those persons in the prime of life.

The Medical Examiners Act of 1970 was passed by the Legislature without State funding and the burden of the costs for implementation of the program has been almost totally with the County Commissions. And now, the Medical Examiner's Commission is requesting partial State funding from the 1973 legislature in order to fully implement this much needed program. This program will significantly benefit the citizens, the law enforcement officials, the courts and the physicians of the community and is deserving of the community support of these agency groups. Statewide funding will provide benefits to all, and will decrease and help to minimize the ad valorem tax costs of such service.

In summary then, partial State funding will assist in accomplishing the following:

1. Create a uniform Medical Examiner's System in the State of Florida, comparable to the State Attorney system now in operation.
2. Improve the medicolegal capabilities of the State and counties in determining with reasonably certainty, the cause of death.
3. Provide partial State funding for the Medical Examiner Program as required by Chapter 406, Florida Statutes and
4. Relieve the counties of part of the tax burden imposed by Chapter 406, Florida Statutes.

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Dr. Fulghum is the Chief of the Bureau of Adult Health and Chronic Diseases, Division of Health, Department of Health and Rehabilitative Services, Jacksonville.

Dr. Davis is the Chairman, Medical Examiner's Commission, Professor, Department of Pathology, University of Miami School of Medicine and is the Dade County Medical Examiner, Miami.

Mr. Hinson is a Health Field Worker, Bureau of Adult Health and Chronic Diseases, Division of Health, Jacksonville.



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WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated. Usage in pregnancy.** (See above **WARNINGS** about use during tooth development.)

Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The antianabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal diseases, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis inflammatory lesions (with monilial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.
Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.
SUPPLIED: 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

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Editorials

Utilization Review

The trend to a changing mode of health delivery has been evident since third party payments placed a premium on hospitalization as opposed to ambulatory care, yet there is a spreading conviction that inpatient use of hospitals is excessive and unnecessary. The availability of an increasing number of hospitals beds, together with guaranteed payments, undoubtedly has induced an attitude of this being the convenient way for the patient and the physician; however, the yearly rising cost of hospitalization has made utilization a public issue with such questions as: "Does the patient require general hospital care? Must the needed tests be done on an inpatient basis?" It's obvious the present rules are not entirely reasonable or compassionate for it's difficult to schedule several separate consultation visits for an elderly, feeble or crippled individual while withholding his diet for laboratory and x-ray tests and at the same time maintaining his medications, all as an outpatient. Rules should follow methods of practice best for the patient, not the other way around.

In the absence of market-force restraints on any product, some form of regulatory control appears necessary but, at the present, voluntary professional self regulatory controls over hospital admissions have appeared ineffective. Since it has not previously worked for other professions or businesses, government agencies and third parties are doubtful that utilization committees will ever become fully effective. Since it is neither easy nor pleasant for physicians to get tough with fellow colleagues of a hospital staff over medical judgments with little assistance from hospital administrators, can there be any future in utilization committees made up as they are today? In an industry whose annual cost already exceeds the national defense, whose services are in ever increasing demands by the public and whose product is being promised to all in many campaign speeches, the faint hearted are daily telling us that regulations can not be avoided.

Utilization control should be a more productive process rather than a negative one designed only for cost containment, and should convince the public and the health professions that every reasonable precaution is being exercised to protect and enhance quality as well as to induce economies, the two not necessarily being inconsistent. While the quality of medical care delivery does not easily lend itself to cost accounting, determining optimal patterns of care, then objectively comparing actual performance with this standard, appears to be a logical and equitable way of judging one's work. Although exclusive physician involvement prevents exposing the privileged communication between a patient and his doctor, public confidence does not appear to be forthcoming without effective quality monitoring devices to justify rising hospital costs. Appropriate considerations for hospital utilization include factors other than medical, providing valid arguments for including social and economic evaluators. This certainly is not out of keeping with Florida's policy of government in the sunshine.

Rushing to adjourn, last June, the AMA sidestepped this controversial issue of the public's demand to monitor physicians' medical decisions and practices, when Pennsylvania delegates introduced a resolution affirming the public's right to be involved in review of doctors' fees in any federally funded medical care program. Arguing that the AMA should realize the inevitability of

the public's demand for the right to oversee expenditures of federal Medicare money, Pennsylvania, failing to gain support, threw its weight behind the resolution, presented by a New England delegation, recognizing the necessity for participation of public representatives in the evaluation of proper expenditure of public funds for health care. This measure failed to pass.

Today, we doctors control the mechanisms of utilization review but our actions are under close surveillance. Unless we wish to lose that control, we must prove that we can exercise it and exercise it properly. What is needed most of all is the wholehearted cooperation by everyone on the medical staff with the peer review of the utilization committee. Obligatory physician rotation on the committee divides equitably the work load at the same time providing consultation with one's colleagues as to how the same disease is regarded in making a diagnosis and initiating treatment. Self education by mature, motivated physicians who can objectively determine their own needs and seek appropriate solutions resulting in delivery of a better quality of patient care is continuing education.

In our efforts to meet economic pressures for cost control and to seek out the few "bad guys," our peer review mechanisms overlook the tremendous challenge and opportunity whereby they might become the most effective single instrument of continuing education and thereby of quality maintenance. Fewer hospitalization claims disallowed by third parties, and less pressure for federal controls should follow.

C.M.C.

A Needed Physician Service

Full support of statewide medical examiner service is a necessity if the State of Florida is to be able to cope with the health and safety problems which arise from a rapidly expanding population. Since the passage of Chapter 406, Florida Statutes in 1970 there has been a gradual and slow implementation of the Act as pathologists were found who would be willing to serve their fellow citizens in this regard. Such a service is basically of a fact finding nature well suited to the training of a pathologist.

The program has now reached the point where specific financial support at the State level is needed to enable the system to run as it was intended. Elsewhere in this issue of the Journal is an article, "The Medical Examiners Act, A Giant Step Forward," which we bring to your attention as another facet of medical service by and under the control of physicians.

Joseph H. Davis, M.D.
Miami

Dr. Davis is Chairman, Medical Examiner's Commission and Dade County Medical Examiner.

Editor's Note: Since the passage of Chapter 406, Florida Statutes in 1970 the Medical Examiners Act has been in the process of careful implementation under the direction of its six man commission and with the administrative assistance of the Division of Health. The commission has now reached the stage where specific financial support becomes necessary in order to fulfill the obligations set forth under the Act. The 1973 legislature is being requested to provide partial State funding for the program. Implementation of the program will be of great benefit to the citizens, the physicians and the law enforcement officers of the community and State. This program, already recognized and in force in a few states, is the wave of the future for the entire country. Public safety depends on factual data of the type derived from a good medical examiner system. This program appears worthy of the cooperation and support of the practicing physicians in Florida.

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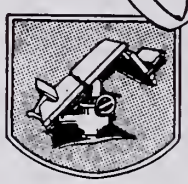
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Therapy of Pancreatic Pseudocysts

Steven Bernstein, M.D.

A localized collection of pancreatic fluid, cellular debris and necrotic material, with or without blood or blood clots and lacking an epithelial wall, is by definition a pancreatic pseudocyst. Such chronic pancreatic collections occur in perhaps 2% of patients with clinically recognized pancreatitis,[1] but clear-cut pseudocysts have been discovered in patients with no clear history of pancreatic disease.[2,3] Because pancreatitis is fairly common, the absolute number of pseudocysts which occur must be large but even at large institutions which serve a population high in alcoholics only three to five cases per year are recognized.[1,2,4]

In the majority of cases, alcoholism, biliary tract disease or pancreatic trauma may be implicated etiologically[1] but in one series of 50 cases, 26% of pseudocysts were believed to be idiopathic.[2] An important cause of "trauma" to the pancreas is abdominal surgery on adjacent viscera which may be blamed for up to one third of traumatic pseudocysts.[2,3] Pseudocysts most commonly form in the base of the transverse mesocolon or in the lesser omental bursa but cysts in the mediastinum, perirenal area and pelvis are not unknown.

Although anecdotal reports of spontaneous resolution of pseudocysts are frequent, such occurrence must be quite rare; current surgical dictum is that ". . . an operation should be performed whenever the diagnosis of a pancreatic pseudocyst is made."[2] It is vital, however, for the surgeon to be sure of his diagnosis; if a pancreatic abscess is mistaken for a pseudocyst and drained internally, complications are universal and death may follow.[5] This should not lead, however, to the practice of allowing suspected pseudocysts to "mature" before operation; operation must be timely, indeed prompt, to forestall the dangerous complications of rupture and/or hemorrhage.[1] If the surgeon finds and recognizes a pancreatic abscess, drainage externally will lead to a good result.[5]

Surgical therapy of pseudocysts may be divided into excision, external drainage and internal drainage. The consensus is that the operation must be tailored to the patient, cyst and surgeon. If the cyst has a firm fibrous wall and is adjacent to the stomach or proximal small bowel, internal drainage is preferred; if, however, the surgeon finds that the wall is unsuitable, external drainage is better. Small cysts may be treated by excision. Drainage into the colon is not recommended. Complications of surgery include bleeding, duodenal obstruction, recurrence, thrombosis of the portal vein, and sepsis.[2] Operative mortality in one series[2] was 6.6%; in that series there was a 32% incidence of complications of all types, which compares with 24% in another series of similar size and patient composition.[1]

Management of pseudocysts is often management of the complications of pseudocysts. It is said that there are 54 major complications of pseudocysts;[4] chief among these are perforation of adjacent hollow viscera, rupture into the peritoneal cavity, massive hemorrhage and pancreatic ascites. Less common, but often catastrophic, problems include bowel obstruction, biliary tract obstruction, rupture into the pleural and pericardial cavities and sepsis. Free rupture into the peritoneal cavity is especially dreaded because of

the high mortality associated therewith; it is encouraging to read that four patients with that complication were successfully managed with peritoneal irrigation and drainage at laparotomy.[1]

Although pancreatic ascites is infrequently reported, it is likely a fairly common problem.[1,3,6] Diagnosis is not difficult if the physician thinks to order an amylase on the ascitic fluid; elevated values are universal and the figures are often astronomical. The protein is characteristically elevated as well; serum amylase may be modestly elevated, or normal. Therapy is usually surgical[3,6] and pseudocysts, clinically unsuspected, are often found.[3] The etiology is not well understood but a slow leak of pancreatic juice from a pseudocyst or a duct disrupted by chronic pancreatitis has been implicated.[3] Operative pancreatography is mandatory to localize the point of leakage; surgical results are generally favorable[3] although an occasional patient has benefited from diuresis and multiple paracenteses.

To summarize, pseudocysts of the pancreas are uncommon but not rare, are attended by frequent and awesome complications and should be managed operatively. The procedure of choice is internal drainage, preferably transgastric cystogastrostomy or fully diverting Roux-en-Y cystojejunostomy,[5] unless the cyst is infected or has an unsuitable wall, when external drainage is favored.[4] Cysts containing malignancy should not be externally drained;[4] when there is active hemorrhage, excision is favored if possible.[1] Operation should not be delayed to await "maturation" of the cyst wall; free rupture or perforation often supervenes while the patient is waiting for surgery.[1] In populations which are predominantly alcoholic, the operative mortality is about 6% and the complication rate 25% to 35%.

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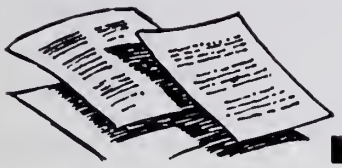
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Letter

Dear Editor:

Inasmuch as the Division of Health is planning to modify its policy on the examination of specimens for gonorrhea, it would be most helpful if the following statement could be published in the JOURNAL.

Recognition that gonorrhea is reaching alarming prevalence has stimulated research for more effective means of identification, treatment and prevention of these infections. Laboratory gonococcal detection has been made faster and more accurate than ever before. Florida physicians should be aware of the recently developed test procedures now available through private laboratories and the State Division of Health Laboratories.

The most significant advance has been in the development of a medium which allows for swab cultures to be mailed without loss of detection sensitivity. This medium is called "Transgrow." Physicians and clinics without diagnostic facilities nearby can now send Transgrow cultures to distant laboratories. This new diagnostic tool is of particular value for the identification of asymptomatic infections in females, and replaces the almost valueless microscopic examination of a stained dried smear of vaginal exudate.

The "Transgrow" medium comes ready to use in screw-cap bottles containing a partial atmosphere of carbon dioxide and has a shelflife of several months. Adequate growth of gonococci may be expected even after delays in shipment of up to 72 hours. This technique, which yields results comparable to the conventional culture method, is available through private and hospital laboratories; or alternatively, the culture bottles may be purchased from various biological supply houses, inoculated, and sent to any of the Bureau of Laboratories regional offices for testing.

In males, the gram stained smear examination of dried exudate has proved to be a simple and effective means for detecting gonorrhea infection, and this service will be continued. With the availability of the "Transgrow" culture method now, the unproductive examination of direct smears from female patients will be discontinued by this agency beginning January 1973.

At the present time there is no reliable blood test for gonorrhea. Intensive research is presently underway to develop such a test. Should this serologic technique become available, the Division of Health will take immediate steps to provide the additional service.

Further information may be obtained from the Division of Health Regional Laboratory in your area.

WILSON T. SOWDER, M.D., M.P.H., DIRECTOR
FLORIDA STATE DIVISION OF HEALTH
JACKSONVILLE

DOCTOR, MARK THESE

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Medical News

Dr. Wachtel Gets AAFP Post

Leo M. Wachtel, M.D., well-known Jacksonville physician, has been elected to the Board of Directors of the American Academy of Family Physicians.

Dr. Wachtel was elected at the Academy's Annual Meeting in New York City in September. He has represented Florida in the Academy's Congress of Delegates for the past 12 years.

Dr. Wachtel is a Past President of the Duval County Medical Society, the Florida Academy of Family Physicians and the Florida Medical Association.

Florida Gets New Dean

The State Board of Regents has approved the appointment of Chandler A. Stetson, M.D., as Dean of the University of Florida College of Medicine, effective November 1.

Dr. Stetson, 50, comes to Florida from the New York School of Medicine, where he has been Chairman of the Department of Pathology for several years. As Dean, Dr. Stetson succeeds Emanuel Suter, M.D., who is now Director of International Education for the Association of American Medical Colleges.

The new Dean is a graduate of Bowdoin College and received his M.D. degree from Harvard University School of Medicine in 1944. He has had training in pediatrics and preventive medicine as well as pathology.

Dr. Stetson and his wife, the former Betty Jean Dill of Rushville, Illinois, have four daughters.

Record Enrollment at Miami

The University of Miami School of Medicine has begun its 20th year of operation with a record enrollment of 533 students.

Class breakdown includes 115 seniors, 117 juniors, 127 sophomores and 135 freshmen. In addition, there are 39 students with doctorates in sciences other than medicine enrolled in the School's special program in which they can obtain M. D. degrees in 18 months to two years.

The student body includes 471 Floridians and 62 out-of-state residents.

Florida M.D. Co-Authors Book

Frank H. DeLand, M.D., of Gainesville, has co-authored the third volume of the *Atlas of Nuclear Medicine,* an illustrated compilation of problem cases in that field.

Dr. DeLand is Chief of Nuclear Medicine at the University of Florida's Shands Teaching Hospital and the Gainesville Veterans Administration Hospital. His co-author is Henry N. Wagner Jr., M.D., Professor of Medicine and Radiology at Johns Hopkins.

Their volume is entitled Reticuloendothelial System, Liver, Spleen and Thyroid.

Family Practice Residency in Gainesville

Starter funds totaling $40,000 will get a family practice residency program under way one year earlier than planned at the Alachua General Hospital in Gainesville.

The program is being developed by the University of Florida College of Medicine's Department of Community Health and Family Medicine and the medical staff of Alachua General. It is expected to begin training residents next July.

The Family Health Foundation of America donated $25,000 of the starter funds, while the Florida Academy of Family Physicians gave $5,000, and the hospital committed $10,000.

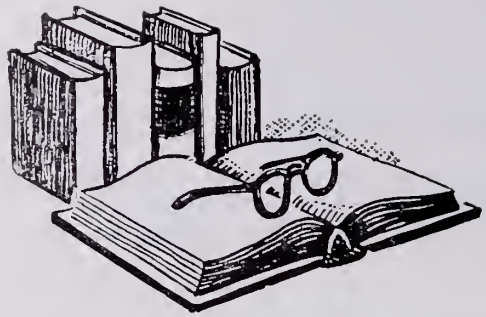
According to Richard Reynolds, M.D., Professor and Chairman of the Department of Community Health and Family Medicine, the Alachua general program has the potential to be one of the best of its kind in the nation.

National Physician's Assistant Project

The American Medical Association and the National Board of Medical Examiners are undertaking a national project leading to the certification of physician's assistants.

AMA and NBME announced that their objective is to determine the best way of developing nationally validated certifying examinations that will ensure the orderly development of the concept of the assistant to the primary care physician.

By AMA definition, a physician's assistant "is a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant."



Book Reviews

SELECTED WRITINGS OF SIR ARTHUR HURST (1879-1944), Edited with a Biographical Introduction by Thomas Hunt, C.B.E., D.M., F.R.C.P. Pp. 218. Price $12.00. London, The British Society of Gastroenterology, 1970. U.S. Distributor, Baltimore, The Williams & Wilkins Co.

This is a memorial volume prepared by Dr. Thomas Hunt for the British Society of Gastroenterology in honor of its founder, Sir Arthur F. Hurst. This book is customarily presented to the physician delivering the annual Arthur Hurst Memorial Lecture.

In this book, I learned that Hurst's work with the bismuth meal in 1906 marked the beginning of gastrointestinal radiology.

Hurst did extensive work on the swallowing mechanism. A paper from the Quarterly Journal of Medicine (1930) entitled "Achlasia of the Cardia" tells us that Hurst, in 1913, suggested that the problem in achlasia was that of non-relaxation of the sphincter rather than spasm and in 1910 introduced the term of achlasia of the cardia (failure of relaxation).

In the section "Aspirin and Gastric Hemorrhage" is reprinted a letter to the British Medical Journal (1941) referring to previous work in 1939; Hurst stated, "the widespread use and abuse of aspirin makes the recognition of its toxic effect of more than academic interest in accumulating evidence of its power to produce severe gastric hemorrhage necessitates the consideration of the possible role of this drug in all cases in which the more common causes of bleeding can be excluded."

In a chapter entitled "Sins and Sorrows of the Colon" (1922) he says, "Colitis should never be diagnosed unless positive evidence is present as obtained by examination of the stools and by means of sigmoidoscope. . . . The sigmoidoscope is one of the most valuable of all instruments used in the investigation of disease—. . . . In my opinion every physician and every practitioner should familiarize himself with a sigmoidoscope."

In a section entitled "Mythical Maladies" (1930) commenting on the excessive use of enemas he writes, ". . . a colon laundry has actually been established in London for the practice of what [an American] writer refers to as the new indoor sport of washing out the intestines."

In the section "Aerophagy" written in 1910, he gives a historical reference to flatulence. "The Emperor Claudius made an effort to overcome the popular opinion that to allow the escape of wind is an offence against decent manners by issuing an edict, which made it lawful for any Roman *"flatum crepitumque ventris in convivio emittere."*

In "Neurasthenia (1971)

"The cure for this ill is not to sit still
And frowst with a book by the fire;
But to take a large hoe, and a shovel also,
And dig till you gently perspire."

This charming book is recommended for those with a historical interest; it would be ideal as a gift to a colleague or a physician in training.

F. Norman Vickers, M.D.
Pensacola

Pathology (6th ed.) edited by W. A. D. Anderson, M.D. Pp. 1,862. 1,566 Illustrations. Price $29.50. St. Louis, The C. V. Mosby Company, 1971.

Although I teethed on Boyd which was quite satisfactory in medical school, I switched to Anderson's PATHOLOGY when I became a resident in Professor Anderson's department. And now, before me, I have a brand new Sixth Edition smelling fresh of printer's ink.

This new edition, proving once again that Dr. Anderson is a superb organizer, follows the format and objectives of previous editions; it is a two volume, comprehensive, easy-to-follow text providing a balanced coverage of the subject of pathology. In keeping with the spectacular advances in biochemistry, cytology, genetics, immunopathology, and ultrastructure, all chapters have been revised, many completely rewritten. Some old contributors have been dropped; new ones

have been added. Unfortunately, in the former group are Dorothy Russell and Jeff Minckler, both authoritative and distinguished writers.

Forty-two chapters are divided about evenly between the two volumes. The "time-tested order of presentation," i.e., etiology, pathogenesis, pathogenic anatomy, clinical manifestations, and prognosis, is followed wherever possible.

In some areas, the writer leaves pathology and enters the realm of physiology as does Dr. Scotti (chapter 4, Disturbances of Body Water and Electrolytes and of Circulation of Blood), but as Dr. Anderson points out in the preface "the borderland of pathology has always been both varying and ill-defined, but never more so than now. Thus, the choice of inclusion or exclusion of many subjects must be somewhat arbitrary."

Now, for a few statistics: PATHOLOGY weighs in at 13 lbs. which makes the volumes very cumbersome and certainly discourages one from carrying them back and forth from home to office or hospital. Even one volume is heavy and a little difficult to work with. There are 1,862 pages versus 1,439 pages in the 5th edition. There are 44 contributors versus 39 in the earlier edition. And, naturally, the price—like everything else—has gone up the inflationary ladder: $29.50 versus $21; nevertheless, for the money, one can't do better than to own this well-written, encyclopaedic work. It's a "must" for the medical student; an aid to the resident and practicing physician, and, with its valuable bibliography including recent developments in the current literature, a treasure-trove for the researcher.

ARTHUR FREDERICK SCHIFF, M.D.
MIAMI

How Sex Can Keep You Slim by Abraham I. Friedman, M.D. Pp. 216. Price $6.95. Englewood Cliffs, N. J., Prentice Hall, Inc., 1972.

This book is built around two phrases: "Make love, not fat" and "Reach for your mate instead of your plate." The author suggests substituting sex for snacks, calculating that sexual activity uses 200 calories, and substituting this for the 700 calorie bedtime snack, you lose a total of 900 calories.

Linking a dull subject with an interesting subject may be helpful, at least to sell books.

F. NORMAN VICKERS, M.D.
PENSACOLA

Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

Cardiovascular Physiology, Second Edition, by Robert M. Berne, M.D. and Matthew N. Levy, M.D. Pp 265. 193 Illustrations. Price $9.25. St. Louis, The C. V. Mosby Company, 1972.

Hematopoietic and Gastrointestinal Investigations with Radionuclides by Albert J. Gilson, M.D., William M. Smoak III, M.D. and Morton B. Weinstein, M.D. Pp. 456. Illustrated. Price $30. Springfield, Ill., Charles C. Thomas, Publisher, 1972.

Synopsis of Pathology, Eighth Edition by W. A. D. Anderson, M.D. and Thomas M. Scotti, M.D. Pp. 1076. 433 Illustrations. Price $13.95. St. Louis, The C. V. Mosby Company, 1972.

A Civilian Doctor in Vietnam by Fred Gloeckner, M.D. Pp. 123. 27 Illustrations. Price $5. Philadelphia, Pa., The Winchell Company, 1972.

Mental Health Training and Public Health Manpower by Stephen E. Goldston, Ed. D., M.S.P.H. and Elena Padilla, Ph.D. Pp. 294. Price $2.75. Rockville, Maryland, National Institute of Mental Health, 1971.

Malnutrition, Its Causation and Control, Volume I and II by John R. K. Robson. Pp. 613. Illustrated. New York, Gordon and Breach, Science Publishers, Inc., 1972.

Current Pediatric Diagnosis Treatment, 2nd Edition, by C. Henry Kempe, M.D., Henry K. Silver, M.D. and Donough O'Brien, M.D. Pp. 1008. Illustrated. Price $12.00. Los Altos, California, Lange Medical Publications, 1972.

A Synopsis of Contemporary Psychiatry, Fifth Edition by George A. Ulett, M.D. Pp. 367. Illustrated. Price $10.90. St. Louis, The C. V. Mosby Company, 1972.

Symposium on Aesthetic Surgery of the Face, Eyelid, and Breast, Volume Four. Edited by Frank W. Masters, M.D. and John R. Lewis Jr., M.D. Pp. 222. 446 Illustrations. Price $35.50. St. Louis, The C. V. Mosby Company, 1972.

Salt The Mysterious Necessity edited by Mark Batterson and William W. Boddie. Pp. 112. Illustrated. Price $6.95. Midland, Michigan, The Dow Chemical Company, 1972.

Medicine in a Changing Society by Lawrence Corey, M.D., Steven E. Saltman, M.D. and Michael F. Epstein, M.D. Pp. 228. Price $6.50. St. Louis, The C. V. Mosby Company, 1972.

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Deaths

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Barry, Andrew J., Starke; born 1923; Tulane University, 1949; member AMA; died August 21, 1972.

Bottari, Giulio C., Tampa; born 1882; University of Naples, 1907; member AMA; died August 24, 1972.

Dicks, Reid E., St. Petersburg; born 1891; Georgia College Eclectic, 1916; member AMA; died June 9, 1972.

Evans, Willis F., Warrington; born 1901; Medical College of Virginia, 1933; member AMA; died August 14, 1972.

Jensen, Jacob R., Orlando; born 1898; University of Maryland, 1926; member AMA; died November 19, 1971.

Langley, Francis H., St. Petersburg; born 1899; Johns Hopkins Medical School, 1930; member AMA; died June 17, 1972.

Larson, Eli, Coral Gables; born 1925; Tufts College, 1951; member AMA; died July 6, 1972.
Levin, Leo M., Miami Beach; born 1908; Ohio State University, 1934; member AMA; died July 30, 1972.

Murphy, Ralph D., St. Petersburg; born 1887; University of Illinois, 1912; member AMA; died May 23, 1972.

Pavlin, Otto B., Bradenton Beach; born 1899; University of Illinois, 1925; member AMA; died June 5, 1972.

Shaar, Richard T., Jacksonville; born 1924; Jefferson Medical College, 1947; member AMA; died July 25, 1972.

Stone, Yale D., Jupiter; born 1896; Ohio State University, 1921; member AMA; died July 19, 1972.

Thomas, William S. Sr., Gainesville; born 1891; Johns Hopkins Medical School, 1915; member AMA; died July 31, 1972.



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NOVEMBER

4, 18, 25 Pediatric Pre-Football Game Seminars, J. Hillis Miller Health Center, Gainesville. For information: George A. Richard, M.D., University of Florida, Dept. of Pediatrics, Gainesville 32601.

11 Pediatric Pre-Football Game Seminars, University Hospital Auditorium, Jacksonville. For information: George A. Richard, M.D., University of Florida, Dept. of Pediatrics, Gainesville 32601.

16-17 First Annual Seminar "Expanding Scope in Diagnosis," Marriott Hotel, Miami. For information: Vicente Rodriguez, 5959 N.W. 7th St., Miami 33126.

DECEMBER

2 Pediatric Pre-Football Game Seminars, J. Hillis Miller Health Center, Gainesville. For information: George A. Richard, M.D., University of Florida, Dept. of Pediatrics, Gainesville 32601.

8-10 "The Spinal Cord Injured Patient," from the Department of Orthopaedics and Rehabilitation, University of Miami School of Medicine, Americana Hotel, Miami Beach. For information: Augusto Sarmiento, M.D., Box 875, Biscayne Annex, Miami 33152.

9 Pediatric Pre-Football Game Seminars, University Hospital of Jacksonville Auditorium, Jacksonville. For information: George A. Richard, M.D., University of Florida, Dept. of Pediatrics, Gainesville 32601.

13-15 Twelfth Biennial Cardiovascular Seminar—"Complications of Myocardial Infarction," Doral Hotel, Miami Beach. For information: Marvin L. Meitus, M.D., 5080 Biscayne Blvd., Miami 33137.

National and Regional Meetings Held in Florida

NOVEMBER

2- 4 International Conference on Trichinellosis, Sheraton-Four Ambassadors Hotel, Miami. Sec.: W. C. Campbell, Ph.D., Merck Institute, Rahway, N. J. 07065.

2- 6 Association of American Medical Colleges, Fontainebleau Hotel, Miami Beach. Pres.: John A. D. Cooper, M.D., 1 Dupont Circle, Washington, D. C. 20036.

6-10 American Society of Tropical Medicine and Hygiene, Deauville Hotel, Miami Beach. Sec.-Treas.: George R. Healy, Ph.D., P.O. Box 15208, Emory University Branch, Atlanta, Ga. 30333.

19-22 Pan American Medical Association, Deauville Hotel, Miami Beach. Dir. Gen.: Joseph J. Eller, M.D., 745 5th Avenue, New York 10022.

DECEMBER

1- 2 American College of Chemosurgery, Balmoral Hotel, Miami, Sec.-Treas.: Richard S. Moraites, M.D., 7721 Montgomery Rd., Cincinnati, Ohio 45236.

2- 7 American Academy of Dermatology, Americana Hotel, Miami Beach. Sec.-Treas.: Frederick A. J. Kingery, M.D., 2250 Northwest Flanders Street, Portland, Oregon 97210.

3- 6 American Society of Hematology, Diplomat Hotel, Miami Beach. Sec.: Steven Robinson, M.D., Beth Israel Hospital, 330 Brookline Avenue, Boston 02215.

4- 6 Southern Surgical Association, Boca Raton Hotel, Boca Raton, Sec.: David C. Sabiston Jr., M.D., Duke University Medical Center, Durham, N.C. 27710.

1973

MAY

21-24 American College of Obstetricians and Gynecologists, Americana Hotel, Miami Beach. Dir.: Michael Newton, M.D., 79 West Monroe Street, Chicago 60603.

JUNE

11-15 Society of Nuclear Medicine, Americana Hotel, Miami Beach. Exec. Dir.: Mrs. Margaret Glos, 211 East 43rd Street, New York 10017.

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Miscellaneous

ADDITIONAL PHYSICIANS URGENTLY NEEDED: GP, internal medicine, obstetrics, pediatrics, and general surgery. Modern office immediately available. Contact I. B. Price, M.D., P.O. Box 819, Quincy, Florida 32351.

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ALLERGIST, 42, certified pediatric allergy. Academic position university-affiliated hospital, head chest & allergy sections. Experienced chest disease, pulmonary function, tuberculosis, respiratory care, etc. Desires association with established practice, group, or consider progressive hospital lab. Prefer coastal areas. Inquiries: John McCloskey, M.D., 2380 Packard Ave., Huntingdon Valley, Pa. 19006.

RADIOLOGIST: Board certified and experienced, Florida licensed. Desires association with hospital, clinic or radiologist(s). Write C-543, P.O. Box 2411, Jacksonville, Florida 32203.

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INTERNIST, 31 years old, board eligible, with military obligation fulfilled interested in group or associate type practice. Available July 1973. Write C-568, P.O. Box 2411, Jacksonville, Florida 32203.

practices available

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IND.

JFMA

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

VOL. 59, NO. 12

DECEMBER 1972

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A Christmas Prayer

Let us pray that strength and courage abundant be given to all who work for a world of reason and understanding ✣ that the good that lies in every man's heart may day by day be magnified ✣ that men will come to see more clearly not that which divides them, but that which unites them ✣ that each hour may bring us closer to a final victory, not of nation over nation, but of man over his own evils and weaknesses ✣ that the true spirit of this Christmas Season—its joy, its beauty, its hope, and above all its abiding faith—may live among us ✣ that the blessings of peace be ours—the peace to build and grow, to live in harmony and sympathy with others, and to plan for the future with confidence.



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and a few may need counseling
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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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(diazepam)

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JFMA

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

DECEMBER, 1972 • VOLUME 59 • NUMBER 12

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President's Page



Your New Professional Liability Program

By the time this page reaches print, you will have seen information about your new professional liability program and your application should be on file in Jacksonville.

Your Board of Governors is proud of the new program which we were able to present to you. Our Executive Vice President, Mr. Harold Parham, worked hard and long to set up what we believe to be a model program. For all of you who have been insured with the Florida Medical Association program in the past, the new plan will simply be a new policy based upon your existing application of record and completion of a simple form so that your coverage may begin January 1, 1973.

The first thing that may be apparent to you in the new program is an overall 10% reduction in premiums. Although this is welcomed by us all, this is not the most important change with the new program. The Argonaut Insurance Company is our insuror, and the Harlan Insurance Agency will be our new agent. All claims will be handled from one office—Jacksonville—and the FMA will be in full charge with this new triangular setup. Any questions that our members have can be phoned in by direct line (incoming Wats line 1(800) 342-8349). Another outstanding change will be legal coordination of all claims that arise through one legal firm in Jacksonville. This will save considerable dollars since in the past much of the legal research has been done by several different law offices covering the same ground. This does not mean that a member is not entitled to local legal counsel if a court case should arise. It simply means that the legal work is coordinated by one central office.

Your own local county medical society does have a part to play. A committee appointed by your society will work under a state committee. The new contract provides that this local committee with state review, will have the final say as to whether any malpractice or mistake has been made by a doctor. Even though a man may lose his case in court, if the medical society feels that he has done no medical wrong, the incident will not be charged against the doctor so far as his underwriting or rate structure in the future is concerned. This puts the full responsibility of running a "tight ship" squarely on the back of the local societies. If the loss ratio is too high, then necessarily our premiums will have to go up.

We, on your Board of Governors, feel that we have a good program and hope that it will work successfully for the benefit of our members, the Florida Medical Association, and the Argonaut Insurance Company.

William J. Dean, M.D.



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Calcium Pantothenate	2.5 mg.
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Letters

Dear Editor:

Excellent article, "Abortion Is Not the Answer" by Matthew J. Bulfin, M.D., in the October 1972 JFMA.

I am in complete agreement. Abortion on demand is a disgrace to every physician. Saving lives is the prime function of the physician.

The attitude of those in the medical profession who allow and encourage murder in utero cannot be justified unless we assume there are no spiritual values and God is just a piece of fiction. Most disgusting is the solicitation through the mail and news media. The legal profession also shares in the shame.

If abortion is necessary to save the life of the mother, this is a different consideration; if indicated, after gynecologic consultation rather than at the convenience of the patient. As we all know the former reason is extremely rare—the latter extremely common.

Man, the highest form of life, sinks to the lowest form of the animal kingdom by killing his own species. Let's call it what it really is: "Murder in Utero" for profit. If the present abortionists would donate their services free there would be less indications for abortions on demand.

Francis A. Reed, M.D.
Miami Beach

Dear Editor:

I am writing to express my approval of the article, "Abortion Is Not the Answer" by Matthew J. Bulfin, M.D. in the October 1972 JFMA.

I support the viewpoint expressed by Dr. Bulfin and feel that the medical profession has been rushed into support of legislation legalizing easy abortion without adequate consideration of medical, moral and ethical results.

F. A. Streck, M.D.
Ft. Lauderdale

Dear Editor:

I am writing regarding Dr. Matthew J. Bulfin's article in the October 1972 issue of the Journal of the Florida Medical Association entitled "Abortion is Not the Answer."

While his article did correctly point out that there are complications associated with therapeutic abortion just as there are with many surgical procedures and medical treatments, he failed to point out that there are also numerous problems and complications that can derive from carrying an unwanted pregnancy; however, I think the most upsetting aspect of the article was the manner in which the procedures and complications were dramatized. I could not help but be reminded of the flurry of articles in the numerous women's magazines dramatizing the severe cases of thrombophlebitis and pulmonary embolism associated with birth control pills.

His article compared therapeutic abortion to such unrelated events as the Nuremberg Trials and to other unrelated diseases, such as, the incidence of cancer in young American males. No mention was made in the article of the fact that in states where therapeutic abortions have been permitted for several years there has been a decrease in the incidence of septic abortions as well as the incidence of "incomplete abortions."

Also, while terms such as "brutal" and "dehumanizing" were used to describe the experiences of a small number of patients who had had therapeutic abortions, there was no mention made of the brutal or dehumanizing nature of child abuse. Statistics regarding the number of abortions performed in other states were dramatically brought out, however, no mention was made of the number of battered children seen as the result of unwanted pregnancies.

While Dr. Bulfin's right to state his own personal feelings is to be respected, I do not feel that his article should be taken as an indication that all other Florida physicians have similar opinions.

Ralph H. Jennings, M.D.
Lakeland

Dr. Jennings would like to point out that this is a personal opinion and does not necessarily reflect the opinions of his colleagues.

Dear Editor:

Re the reprint on the Good Samaritan on page 44, October 1972 JFMA.

You may be interested to know that the publisher of *Emergency Medicine* has publicly offered a cash award to anyone who could identify a true case where a physician was sued for his acts as a Good Samaritan. To date, he has been unable to find a single case.

If the moving article you published is not enough inducement for us to act when our services are needed, the fact that suits against Good Samaritans have been nonexistent should clear any remaining doubts as to what we should do.

William T. Haeck, M.D.
Jacksonville

Dear Editor:

I found several articles in your October issue of such general interest that I would like to commend your magazine and urge that the surveys and comments be called to the attention of the press.

I refer to the survey results of physicians' smoking habits, use of illegal drugs in college and the opinions and facts expressed in "Abortion Is Not the Answer." I believe that any of these articles could be drawn upon for news features of interest and value to the general public.

Linda H. Yates, Managing Editor
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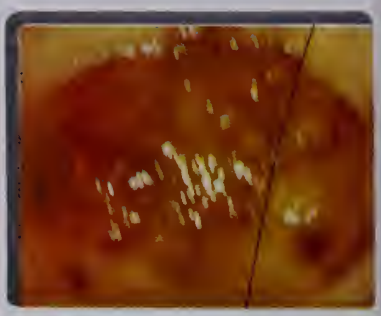
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.
DECEMBER, 1972 • VOLUME 59 • NUMBER 12

Characterization of Intracranial Neoplasms By Dynamic Radioisotope Imaging

WILLIAM M. SMOAK, M.D., JEROME J. SHELDON, M.D., AND ALBERT J. GILSON, M.D.

Abstract: Noninvasive screening with radioisotopes of patients suspected of having intracranial disease may yield an answer as to the presence or absence of a neoplasm. If the passage of the radioisotope bolus is evaluated for time-sequence information, similar to neuroradiologic interpretation, a specific lesion is often suggested.

The brain scan is now well accepted as a screening procedure for patients suspected of having intracranial disease. Until recently, a brain scan consisted of static radioisotope scintillation images of the anterior, both lateral, and the posterior aspects of the cranium. With the introduction of the Anger scintillation camera and increased availability of the low radiation exposure, high photon flux radioisotope, Tc^{99m}, the additional information has become available from dynamic imaging of the radioisotope bolus as it passes through the vascular system. Since the bolus of Tc^{99m} is passing through the vascular system and because of an imaging sequence similar to contrast cerebral angiography, we thought it might prove of value to compare the findings in intracranial neoplasms seen by these two techniques.

From the Division of Nuclear Medicine and Neuroradiology, Department of Radiology University of Miami School of Medicine at Mount Sinai Hospital, Miami Beach.

Presented at Eleventh Annual Meeting of the Southeastern Chapter, Society of Nuclear Medicine, Oct. 30, 1970, Cincinnati; the X Interamerican Congress of Radiology, May 19, 1971, San Juan, Puerto Rico, and at the Second Annual Special Procedures Seminar, Jan. 12, 1972, Miami Beach.

The well documented circulatory patterns of certain common intracranial neoplasms as demonstrated by carotid arteriography were applied to the interpretation of the dynamic brain images in an attempt to predict histopathology. Our experience in over 300 correlations, comparing cerebral angiography and dynamic radioisotope imaging, has led us to conclude that we may correctly predict certain dynamic imaging patterns that appear in arteriovenous malformation (Fig. 1), glioblastoma multiforme (Fig. 2), meningioma (Fig. 3), and metastasis (Fig. 4). The practicing physician should be aware of this capability, and its potential for improved patient care by expediting diagnosis and therapy.

Materials and Methods

Dynamic radioisotope imaging is performed routinely prior to recording conventional static brain scan images. These studies are obtained from a commercially available Anger scintillation camera (Nuclear-Chicago, Pho-Gamma III, high performance) using a high sensitivity, parallel hole collimator. Twenty millicuries of Tc^{99m} are injected rapidly into an antecubital vein. A 35 mm time-lapse camera, operating at a speed of approximately one frame every two seconds, records the passage of the bolus of radioactive material through the brain. Either the anterior, vertex, lateral, or posterior projections may be selected, the initial choice of projection being predicated upon the presenting symptomatology of the patient. On rare occasion, we find that several views are necessary for optimum delineation of a lesion.

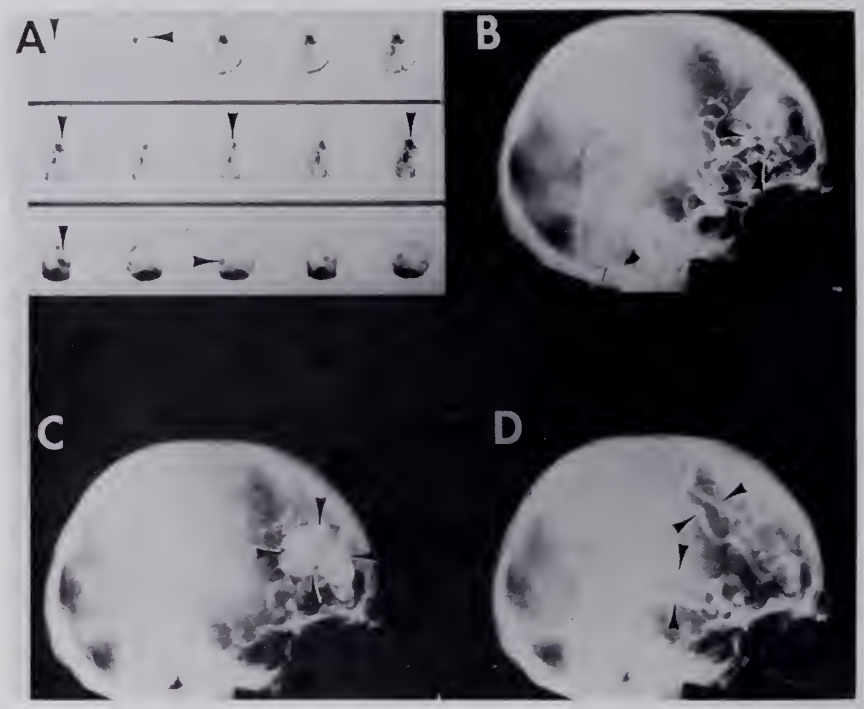


Fig. 1.—Left frontal arteriovenous malformation. Radioactivity appearing in the left frontal region early in the arterial phase (arrows-top, A) gradually increases and then decreases in intensity, then increases again (arrows-2nd row, A). This corresponds to the well circumscribed lesion seen on the static scan (arrows, bottom row, A). On the carotid arteriogram hypertrophied anterior and middle cerebral artery branches (arrows, B) supply an arteriovenous malformation (arrows, C) which drains to interhemispheric and basilar veins (arrows, D).

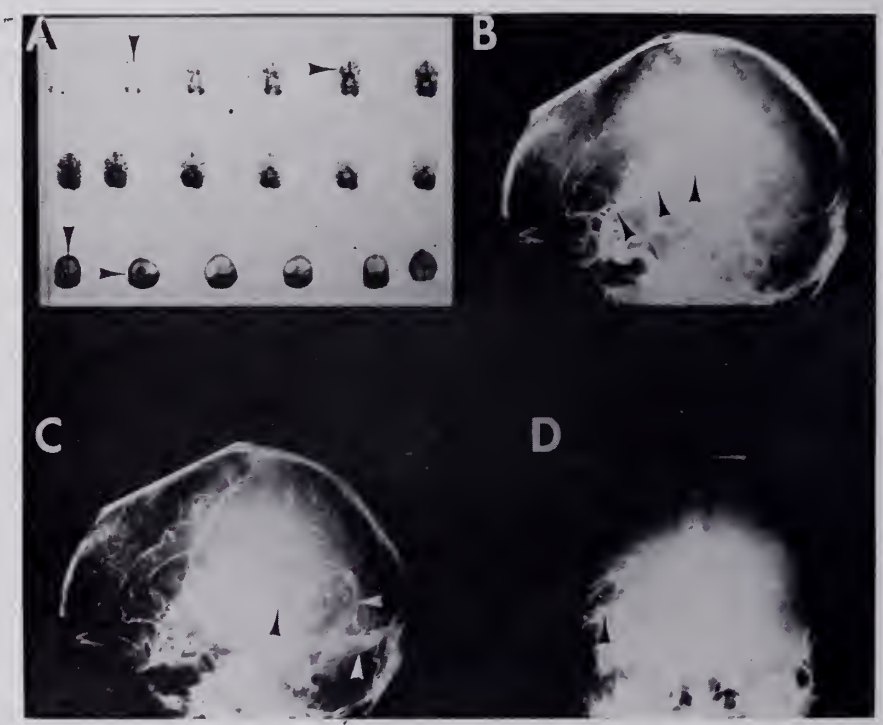


Fig. 2.—Right temporal glioblastoma multiforme. Increased radioactivity in the right middle cerebral artery distribution in the arterial phase (arrows, top row, A) washes out and does not reappear (middle row, A). This corresponds to the right temporal lesion seen on the static scan (arrows, bottom row, A). The carotid arteriogram demonstrates a temporal lobe mass elevating the middle cerebral artery (arrows, B) with a mottled tumor stain (black arrow, C) and early draining veins (white arrow, C). Compare the tumor stain projecting over the middle cerebral artery distribution on the frontal projection (arrow, D) with radioisotope images (arrows, A).

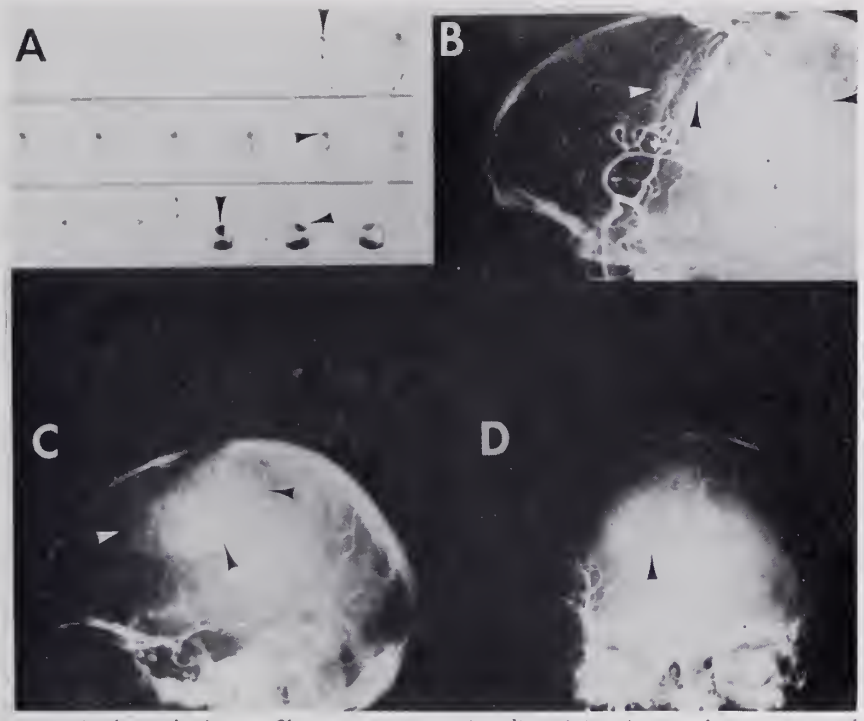


Fig. 3.—Right parasagittal meningioma. Slow appearance of radioactivity during the late arterial phase (arrow, top row, A) reaches its maximum intensity during the venous phase (arrow, middle row, A) and retains radioactivity. This corresponds to the well circumscribed parasagittal lesion seen in the static scan (arrows, bottom row, A). The arteriogram reveals a hypertrophied middle meningeal artery (vertical arrow, B) supplying a tumor mass (horizontal arrows, B) the stain of which persists late into the venous phase (arrows, C). Parasagittal mass with beginning staining in the late arterial phase (arrow, D), appearing much like the radioisotopic images (A).

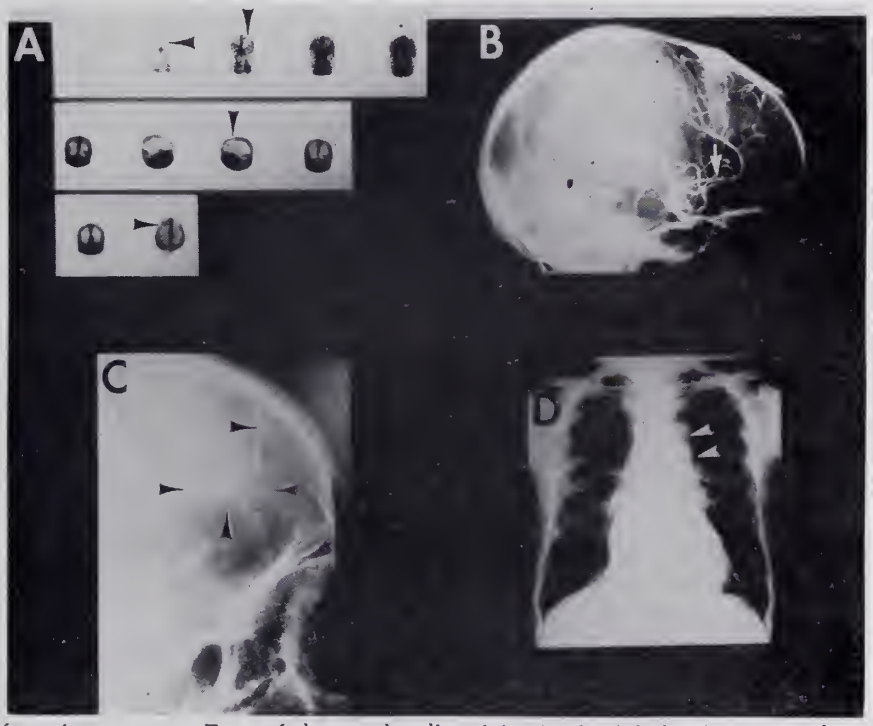


Fig. 4.—Left frontal metastases. Zone of decreased radioactivity in the left hemisphere is demonstrated in the early arterial phase of the dynamic study (top row, arrows, A). This disparity in activity between the two hemispheres is no longer apparent during the following venous phases and corresponds to the well localized area appearing in the frontal lobe on the static scans (arrow, middle and bottom row, A). An avascular mass in the frontal region on the carotid arteriogram is displacing the anterior portion of the middle cerebral artery (arrow, B). There is a very faint tumor cloud present in the venous phase, (arrows, C) with draining vein (top arrow, C). The primary bronchogenic carcinoma can be seen in the left upper lobe (arrows, D).

After the dynamic radioisotope images and delayed static brain scans are interpreted, patients with positive studies are then referred for appropriate biplane contrast arteriography or other indicated radiographic procedures.

Discussion

The angiographic establishment of a differential diagnosis for intracranial neoplasms is based upon morphologic changes in intracranial vascularity. Displacement of existing vessels may also occur and primarily defines the site of the lesion and only on rare occasion suggests a specific diagnosis. Encasement of existing vessels, tumor vascularity, and a "brain stain" demonstrated on carotid arteriography are more specific findings and are useful histopathologic indicators.[1,2] The presence of these latter changes, as well as the speed of cerebral transit of blood through the lesion, may be detected by the Anger scintillation camera and recorded by the 35 mm time-lapse camera.

We have found that the dynamic radioisotope images in patients with intracranial neoplasms basically follow two patterns. There are lesions with increased activity on the side of the lesion identified later on the static images. Arteriovenous malformations, glioblastoma multiformes, and meningiomas can be highly vascular and typify this group of lesions.[3-5] Early arterial appearance, increased flow to the side of the lesion through the carotid vessel, early washout, and recirculation of the radioisotope bolus may be present and point towards an arteriovenous malformation (Fig. 1).

Although we have not identified recirculation in a glioblastoma multiforme, this lesion otherwise may appear quite similar on the dynamic radioisotope study to an arteriovenous malformation (Fig. 2). There is intensification of the lesion on the static scan in the glioblastoma, whereas the arteriovenous malformation will rapidly decrease in activity comparable to a fall in blood pool activity. The third lesion in this category, meningioma, may be distinguished by its delayed appearance on the dynamic radioisotope study (Fig. 3). The meningioma normally will first appear in the late arterial phase, with a progressive increase in the capillary phase, and little evidence of washout of the radioactivity in the venous phase.[5]

Contrast these with an example of a neoplasm demonstrating decreased radioactivity on the dynamic scan on the side of the lesion as seen on the static images (Fig. 4). This is an example of an intracranial metastasis with associated edema and little evidence of neovascularity.[6] This combination of findings is also common in cerebral hematomas, brain abscesses, and low grade astrocytomas.[1,2]

It is important to emphasize that the radioisotope dynamic imaging sequence, like contrast angiography, may not always suggest an etiology and, in fact, may not demonstrate any change in the regional vascularity. However, if vascular changes are present, the dynamic radioisotope images can often suggest the specific etiology.

Conclusion

Time sequence observation of the intracranial passage of the radioisotope, Tc^{99m}, parallels the vascular phases (arterial, capillary, and venous) of carotid arteriography. The temporal appearance and disappearance of activity in intracranial neoplasms can mimic the well known temporal behavior of tumor stains on carotid angiography. Examples have been presented of successfully applying this latter knowledge to dynamic brain imaging to aid in predicting the histopathology of the lesion.

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▶ Dr. Smoak, Division of Nuclear Medicine, University of Miami School of Medicine, P.O. Box 875, Biscayne Annex, Miami 33152.

Past experience should be a guide post, not a hitching post.

Endocrine Vaginal Cytology Terms, Technique and Significance

Daniel O. Hammond, M.D.

Abstract: The important place of endocrine vaginal cytology in sex hormone monitoring is discussed. The upper lateral vaginal wall is the usual source of the cytology spread used for this purpose. The cells of the layers of the squamous epithelium are described and named. The various expressions and indices used to describe the cell populations are discussed and the maturation index is described as the most informative of these. The clinical application of the cytological findings is described.

The recent increase of interest in the use of female sex hormones in medicine has emphasized the need for effective criteria for diagnosis and treatment. Obviously, the time-honored urinary steroid assays are still the most valid laboratory tools in this discipline. However, these tests are expensive, cumbersome and time consuming. They cannot easily be used by the clinician who must respond to the dynamic requirements of day-to-day diagnostic problems. The steroid biochemist would be the first to admit that the chemicals measured in the lab may not be the active principles influencing the tissues under study.

While hormone therapy has increased in scope, a parallel development has occurred in the field of endocrine cytology, with the wider application of sophisticated measurements of the vaginal smear to patient care. The vaginal mucosal cytogram is a convenient, inexpensive, painless and rapid means of evaluating the effect of all hormones on this genital end organ. This is as it should be, since the vagina is the most sensitive of all the genital end organs to sex steroids, particularly estrogens, and since the response of this tissue to steroids is the perfect in vivo assay of biologic activity.

Basic Guidelines

There are some basic guidelines in endocrine vaginal cytology that should be described. These statements must be prefaced by admitting that not all the people who are experts in this matter agree on all the basic items. Also, the interested pathologist and the cytologically-aware clinicians have been involved in a controversy about the proper site of the transition from pure, raw laboratory numbers data to the endocrine diagnosis of the patient. It will be assumed for the sake of this presentation that certain basic techniques are accepted and that the clinician should be the final arbiter of the test results.

The first basic guideline concerns the source of the smear. It is widely agreed that the smears from the cervix should not be interpreted for hormone effect, since the infection and/or dysplasia so common in this area will alter the results. The posterior fornix pool is used by a few cytologists but the majority of cytologists prefer smears from the lateral upper third of the vaginal wall. If there is obvious infection on the smear, as evidenced by the impressive presence of other than Doederlein bacilli or of leucocytes, hormonal interpretation should be postponed until the infection is controlled by local treatment with a non-hormone containing medicine. The source of the smear should be dictated by the experience of the cytologist who will read it, since his dedication to and experience with his specific technique will influence his accuracy.

The cytogram should be obtained by gently rolling a cotton-tipped applicator, preferably lightly moistened with normal saline, against the vaginal wall followed by rolling of the applicator on a slide. Spreads obtained by smearing the applicator are not as consistent in their interpretation. Some cytologists advise the use of a hard applicator like a tongue blade and the smearing of the sample on a slide. It is difficult to standardize pressure using this tool, and since it is a surface exfoliative phenomenon that is evaluated, tools that scrape off more than the surface cells may mislead the observer.

Classification and Terminology

The semantic problem of classification and terminology is the next item for discussion. The vaginal mucosa is a squamous epithelium and, when healthy and stimulated by sex steroids, will mature from a small, round cell having a large nucleus to a large flat cell with either a small pyknotic nucleus or no nucleus at all. The small basal cell is seldom seen except in smears from severely atrophic or ulcerated vaginas. The vast majority of the lower cells are the lower representatives of the intermediate class. These are known as parabasal cells; they are slightly larger and less round but they are still thick. As the cells mature under the proliferative influence of hormones, the true intermediate cell is seen. These are flat large cells with progressively smaller but still vesicular nuclei. Eventually, this process leads to the appearance of the large flat cell with the small pyknotic nucleus (6 micra or less by definition) known as the superficial karyopyknotic cell. The terms "cornified" and "pre-cornified" are no longer acceptable since keratin is rarely found in the vagina. The superficial cells are the last recognizable layer before the nucleus is lost and the cell sloughs off into the vaginal lumen. It is important to realize that these classes are not static and that major population changes can occur within a matter of hours. Moreover, when these cells are counted, there is a 5-10% experimental difference, partly because the distinctions between the parabasal and intermediate classes are not sharp and partly because the technician requires considerable experience for reproducibility. It is therefore foolish to think of these class distinctions as hard and fast, even though the basic definitions are fairly stable.

The staining technique used to demonstrate these cells varies with the cytologist. The early popularity of the Papanicolaou stain has decreased as faster, more convenient polychrome stains were developed. Recently, rapid staining techniques have been introduced that make it possible to bring the cytologic method into the clinician's office.

Having examined the cytogram, the cytologist must then address himself to the problem of communication with the clinician. In the past, cytologists have reported their subjective interpretations of the slides in general syndrome-oriented terms. Recently, there has been a tendency to express the cytogram readings in numerical indices in an attempt to reduce the interpretations to objective terms. There are several indices that have been used in the past and a new one that promises to be very useful.

The Karyopyknotic Index is a measure of the percentage of cells that have pyknotic nuclei. Since pyknosis is a final step in the maturation of the nucleus, it is found in all the superficial cells and can therefore be used as a criterion of maturity. Unfortunately, pyknotic nuclei are to be found in all layers of the vaginal epithelium as a result of degenerative changes. The index must then be expressed as "pyknotic nuclei less than 6 micra in diameter" to be truly a mark of maturity.

The Eosinophilic Index is a measure of the cells that are acidophilic (eosinophilic) in a polychrome stain. Although there is still no obvious histochemical criterion for this characteristic, the more mature cells reveal a larger percentage that is acidophilic. Again, acidophilia occurs in all cell layers, most often associated with infection and staining artifacts.

The newest clinical index available for communication is the Maturation Index. This index lists the percentage of cells in the parabasal, intermediate and superficial class in the following manner: parabasal/intermediate/superficial as 0/0/0. In this index, the least mature is to the left, the most to the right. Confusion was introduced into this concept when a prominent drug company popularized a slightly different form as the "femininity index." In this latter index, the same style is used but the least mature is to the right and the most mature to the left; viz, superficial/intermediate/parabasal. It is important to determine which method is used by the cytologist in order to properly interpret the results. Hopefully, the Maturation Index will eventually supersede the femininity index, since the former is more consistent with other clinical indices in medicine in the direction expressing maturity. Supplementary characteristics describing vaginal cytograms are necessary, since morphologic changes involving size alone are no longer completely rewarding. These are the presence of degrees of curling, folding or wrinkling and crowding, sheeting or plaque formation. The significance of these two items must be left to more exhaustive discussions.

The vaginal mucosal surface changes reflect the general metabolic milieu of the mucosa. This epithelium is exquisitely sensitive to estrogen and progesterone. It is also sensitive in a lesser extent to the other steroids and even some nonsteroid drugs occurring endogenously or exogenously in

the human organism. Although it is helpful to think of these chemicals as having unique effects on the mucosa, the physiological reality is that the end products of both the ovary and the "other gonad," the adrenal, as well as their metabolites influence this mucosa. As a result, the endocrine vaginal smear is a quantitative and qualitative expression of the interplay of several different chemical factors and other circumstances. It is true that during sexual maturity, the ovary is the major influence on the vagina. It then follows that, during the active phase of the ovarian function, one can use the information garnered from the cytogram to surmise the condition of the ovary and its output of hormones, along with adrenal steroids. The vagina as an end organ expresses this sum total; the experienced cytologist, along with the experienced endocrinologist, can draw presumptive conclusions from this information. Some precautions are in order. The unwary clinician who assumes that the vaginal cytogram development can be directly equated to estrogen metabolism is treading a slippery path. It is now recognized by all thoughtful experts that there are many extenuating influences on the vaginal cytogram and that any such conclusion is doomed. Moreover, where experiments can be set up evaluating single hormone effects in vivo in the human, the prime observation was that no linear relationship between dose and mucosal maturity could be demonstrated as applying to all patients. In other words, a small dose that would markedly influence one vagina might not even influence another. Therefore, any absolutes applied to interpretation must be held suspect. This item is particularly true when one considers the case of the postmenopausal woman. If there were a linear relationship as previously mentioned, all postmenopausal women should show an atrophic mucosa. Yet, a recent survey showed that in patients many years after the menopause, up to 10% still had a superficial cell pattern, the most mature that is possible.

In the event that the vaginal mucosa is not available for this method, a clean urine centrifuged for a sediment spread will be almost as valuable. The urethra and much of the bladder in the female originates from sex-hormone-dependent epithelial tissue and will respond to hormones just like the vaginal mucosa.

Conclusion

The vaginal hormone smear method can be applied to the diagnosis and treatment of many endocrine-related conditions. Dysfunctional bleeding, primary and secondary amenorrhea, accidents of pregnancy and evaluation of hormonal support in these conditions, diagnosis of "biologic term" in pregnancy, determination of the fact and timing of ovulation in fertility problems, evaluation of hormone withdrawal in the perimenopause and postmenopause era—all of these will benefit from endocrine evaluation accomplished from the endocrine vaginal smear. There are only two diagnostic smear patterns. These are the totally parabasal smear, indicative of complete hormone lack, and the totally superficial smear, indicative of unopposed estrogen effect. All other cytograms must be interpreted in terms of the condition of the patient and the evidence on the slide. It is therefore urgent that a complete endocrine history be available to the cytologist; it is almost always necessary to have serial slides to effectively use this method. The interpretation of these slides is a matter of experience. For those who wish to use rapid staining methods in order to utilize the technique in their office, a number of books and survey articles are available.

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A gem can not be polished without friction nor man perfected without trials.

Dose Schedule in Antifungal Therapy

Charles Carter, M.D.

Abstract: The convenience of one a day dose of medication in any therapy has proven very beneficial. The effectiveness of Griseofulvin with this regime has been debated for some time. In order to provide further evidence, 65 patients with fungus infections were selected. Fulvicin was administered in a randomized double-blind evaluation in either once a day or four times a day schedule. Patients ranged in age from 14 to 18 years. The severity of the disease was marked in 20, and moderate in 45. All the cases accepted in this study were proven by positive fungus culture. Patients were evaluated weekly, and treatment continued until there was complete clinical and laboratory cure. When there was no improvement in an appropriate period of time, treatment was discontinued. Concluded from this study that there was the same cure rate from either treatment regime. On the basis of time and convenience, the single daily dose would be preferable.

Fungous infections of the scalp and, to a lesser degree, the skin, although not too common an occurrence in hospitals and institutions, can be disconcerting when they do arise. Although these infections are particularly inconvenient among institutionalized children, they become more disturbing among children who are mentally retarded and incapable of expressing themselves in relationship to the infection.

Our institution is primarily designed to care for mentally defective, epileptic and spastic children and adults. Obviously, under such circumstances, fungous infections could be a custodial problem of large proportions. Any preparation which could reduce, control or eliminate this difficulty would be particularly desirable.

Griseofulvin has demonstrated its fungistatic effectiveness and is specifically active against superficial fungi caused by tinea of the scalp, beard, body, hands, feet, fingernails and toenails.

One of the commercial griseofulvin preparations, Fulvicin-U/F®*, a micronized version of griseofulvin, is usually given orally in divided doses. However, since its small particle size provides a much greater surface area for absorption, very high blood levels of the compound have been noted. One would assume, therefore, that possibly a once-a-day dosage of the 500 mg. tablet would be as effective and more convenient to administer than a smaller strength tablet (125 mg.) given in divided doses.

The arrival of warm weather provided an opportunity to test this hypothesis since fungous complaints are higher than usual during this period.

We decided to set up a study for determining whether a single daily dose of a 500 mg. tablet of Fulvicin-U/F was as effective as a lower strength given in divided doses in the treatment of fungous infections of the skin, hair and nails.

It was hoped that if a single dose routine proved effective, it would offer the physician and the institution an easier and less troublesome method for administering the drug and would also help reduce nursing staff man-hours in drug administration. Moreover, if there was little or no difference it could be used more widely in outpatients and offer assurance to the physician that his patients were not miscalculating or forgetting the dosages taken as so often occurs on q.i.d. schedules.

Patient Selection

In order to determine if once-a-day dosage of 500 mg. Fulvicin-U/F was as effective as a lower strength given in divided doses, 65 patients, 46 male, 19 female, were selected for a randomized double-blind evaluation. Thirty-four patients received 1 tablet Fulvicin 500 mg. o.d. and a placebo of Fulvicin 125 mg. q.i.d. and 31 patients received 125 mg. Fulvicin-U/F q.i.d. and a placebo of Fulvicin-U/F 500 mg. o.d. All the patients ranging in age from 14 to 18 years were hospitalized.

Dr. Carter is Medical and Research Director, Sunland Hospital at Orlando.

Table 1.—Results—Comparing Fulvicin-U/F O.D. Versus Q.I.D. Dosage.

	VISIT 2-6		VISIT 7-11		VISIT 12-16		VISIT 17-21		VISIT 22-26		VISIT 27-31		VISIT 32-34	
	A	B	A	B	A	B	A	B	A	B	A	B	A	B
Excellent	7	2	16	13	5	9	2	2	4	1	0	2	0	1
Good	31	28	51	52	12	19	10	7	5	4	0	10	0	4
Fair	91	86	42	53	24	27	14	20	1	16	0	5	0	0
No Effect	34	38	0	0	0	0	0	0	0	0	0	0	0	0
Not Spec. or No Visit	7	1	61	37	129	100	144	126	160	134	170	138	102	88
Total	170	155	170	155	170	155	170	155	170	155	170	155	102	93

A = Once-a-day dosage — 500 mg. tablet
B = Four times a day dosage — 125 mg. tablet

Four patients had tinea pedis, 28 tinea cruris, 1 onychomycosis, 17 tinea capitis, 12 tinea cruris, 1 tinea corporis and capitis, 1 tinea pedis and onychomycosis, and 1 tinea corporis and cruris. The severity of disease was considered marked in 20 patients and moderate in 45.

Initially, 30 were KOH positive, 34 were KOH negative and one was not specified. Thirteen initial cultures were positive for T. rubrum, 3 Microsporum sp., 9 M. canis, 11 M. audouini, 8 Trichophyton sp., 7 T. mentagrophytes, 4 T. tonsurans, 5 Epidermophyton floccosum, 1 Candida sp., 3 Candida albicans, and 1 Cladosporium.

Only standard and recommended doses were to be used.

Patients selected for the study were to be divided on a random basis into two equal treatment groups. Half were to receive the medication once a day and the other half four times a day.

The double-blind design was accomplished in the following manner:

Materials were packed with two codes, a complete master list and a set of individual envelopes for each specific patient. In this way if any difficulty arose (sensitivity, etc.) with a particular patient, the envelope could be opened without breaking the code. Thus, the study would remain blind for the remaining patients.

All patients were to receive one large tablet after breakfast and one smaller tablet on a q.i.d. basis. Those patients receiving the active medication in the single large pill were given a placebo on a q.i.d. schedule, and vice versa. No concomitant antifungal medications were to be administered during the study period.

Clinical assessment of patients was to be made weekly. Treatment was to continue until there was clinical and laboratory evidence of "cure." Responses depended entirely upon the patients and the site of the lesions. If there was no improvement in an appropriate period of time (at least one month for skin lesions and two months for scalp lesions), treatment with Fulvicin-U/F was to be discontinued, and the diagnosis reviewed.

The following criteria was established to determine the results of the study:

Excellent—Clinical and laboratory cure (100%)

Good—Marked clinical improvement (50%-75%)

Fair—Partial clinical improvement (25%-50%)

Poor—No change clinically (0-25%)

Laboratory Tests

Microscopic examinations for fungi were made before treatment and after clearing of the lesions in all cases. In addition, cultures were taken before treatment began. If the condition persisted beyond an expected appropriate treatment time, (two weeks for skin lesions or four weeks for scalp lesions) another culture would be taken.

Conclusion

The results for our study (65/65 clinical and laboratory cures) indicated no difference with the use of Fulvicin on a once-a-day basis as against a four times a day basis. Statistically, comparison of treatments at each visit or number of days to "cure" failed to indicate any significant treatment differences ($p<.10$) (Table 1). Thus, from the standpoint of time, personnel and the inconvenience of a four times a day dosage, the single daily dosage could be used and would, of course, be preferable.

Dr. Carter, P.O. Box 3513, Orlando 32802.

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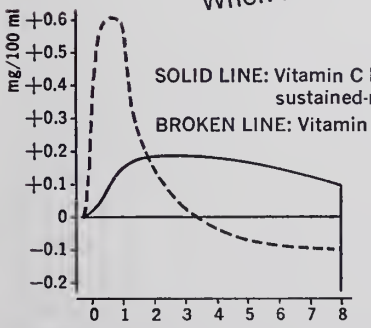


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Special Articles

The Continuing Need for Physician's Assistants

Richard A. Henry, M.D.

Abstract: There is evidence that the need for health care services will outstrip conventional methods of delivering these services, notwithstanding the increase in physician population. Support is given to the physician's assistant concept as a quantitative method of improving health services and it is proposed that physician's assistants will have a favorable impact on maldistribution through making the isolated physician's position tenable.

A letter from a 15-year-old from a community of 17,000 population where there are seven active physicians, three dentists, and a 100 bed JCAH approved hospital is germaine to this subject.

> Dear Dr. Henry,
>
> I am from —, Florida. In the — Junior High School one of our teachers has assigned a report for all the kids in her classes. Part of our report is to gather all the information we can get on what we would like to be when we get older. I am 15 years, and, would like to be a Dr. of medicine.
>
> You see we don't have very many Doctor's here in —. But what little we do have are know use. The doctor's here are so over worked and so tired, that they can't even take 5 minutes to eat, let alone time for me. So doctor if you don't mind, and it's no trouble would you please send me all the information you can on doctorty.
>
> Sincerely,
>
> P.S. Would you please show me the formla used in math for doctors.

Dr. Donn L. Smith, Dean of the University of South Florida College of Medicine in Tampa, asked in the JFMA (Jan., 1972): "Is there a true shortage of physicians or a simple maldistribution problem?" Also, he writes, "To provide a poor quality of care to more people because such care is slightly better than none is no effective solution; and, in the final analysis may destroy medicine as a profession."

Dr. William J. Dean, President-Elect of the FMA at the January, 1972 meeting of County Medical Society Presidents and Secretaries in Orlando, asked: "Do you think physician's assistants will be needed ten years from now, with the increased enrollment and relaxing of the reciprocity law in Florida?"

Dr. Malcomn Todd, Chairman of the AMA's Council on Health Manpower, states in the October issue of AMA Update that the number of new physicians is increasing nearly three times faster than the number of potential patients. Reiterating this stance in San Francisco at the 25th Annual National Conference on Rural Health in March, 1972, he stated that there were 165 doctors per 100,000 Americans. Put another way, this is a physician-patient ratio of 1:600. Of course the number of "functioning" physicians, federal and nonfederal, who were not engaged in medical teaching, administration, research, or "other," totaled 270,000, or a physician patient population ratio of 1:760. Reviewing Dr. Todd's reasons for optimism, we may cite:

1. Federal grants for construction of new schools. These grants are only for start-up costs and emphasize the fallacy of quantitation production by a subsidy for innovations (meaning shorter periods of education—in the face of an explosion of medical knowledge) in curriculum. The fallacy, as Dr. Emanuel Suter, Dean of the College of Medicine, University of Florida in Gainesville, points out, lies in the fact that only the enlarged beginning class will result in more

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physicians; not, after one year, a shortened curriculum.

2. Encouragement by federal scholarships and student loans; particularly for students from low income families or from rural or urban underserved areas; the logic being that these students will return to these areas. [How unrealistic can one get? Pretty unrealistic—with a tax dollar!]

3. Other juicy items of enticement, recruitment and regimentation of (especially) young physicians to practice in areas where their more sophisticated colleagues would not consider settling.

The "real world" of health care delivery must consider the proportion of personnel capable of delivering health care; the new concepts of health care, and the increasing trend of concentration of personnel in urban and suburban areas to the detriment of care in rural and impacted urban areas.

Factors Increasing Demand

There is not enough physician manpower and often it is essentially inaccessible. These are two separate problems, one dealing with quantity and the second dealing with distribution and both implying a concern for quality of health care. Some idea of the real and relative shortage of physician manpower may be gained from an investigation of the factors increasing demand.

Increases in population, proportion of older people, and nursing home occupancy, increased awareness on the part of the potential patient of the advantages of health care, removal of financial barriers and consideration of health care as a right, all will increase need or demand for physician services. Adding together all these factors mentioned here: a population increase of 3.4 million people per year; the shift from 6% to 12% of our population over age 65 in this country during the past 20 years (elderly patients requiring four times as much health care in whatever units one measures it, including physician time); the rise from 600,000 nursing home occupants to 1 million in the past five years; the acceptance by 50% of the population that they should have yearly exams, pelvic exams, breast exams, Pap smears, etc., (when 20 years ago the proportion was 10%); and finally, the removal of the cost barriers by deficit financing with literally unknown impact, add up to an expected minimal increase in physician task demands of 50%. Where are we to find 135,000 more physicians? This need for manpower is imminent.

Another aspect of physician task demand may be seen by comparing the physician of 40 years ago to the physician of today. The physician of 40 years ago may have comfortably cared for 3,000 patients or more while the physician today is hard put to be a good family physician for 1,000 people. But then the armamentarium of the physician 40 years ago, the techniques, knowledge and tools that were not present at that time contrast with the tasks that the current physician performs.

In addition, what physician 40 years ago was doing routine examinations, Pap smears, breasts, exams for prenatal and postnatal care, well baby exams, head start exams, preschool, presport, premarital, preemployment, preretirement exams. The physician may have encouraged these examinations, but very few patients availed themselves of these and there also was little legislation requiring them. The same thing applies to specialists, only the ratio of physicians to patients is greater than with the family physician.

The point is that there is progressive increase in wants, needs, expectations, demands and acceptance of physician services made by the public every year. There should be some definition of these terms. Needs may be objectively measured but increase yearly because of increased armamentarium of the physician or legislated regulations. Expectations may be what the individual potential patient thinks should be available. Demands may be neither expectations nor needs but rather what the patient is motivated to get up and do something about. However, each of these will have some impact on the request for physician services and this increase has become logarithmic with recent developments.

Additionally the physician, by habit or custom, does every task that has been assigned to him. By accretion he has gathered so many tasks to perform, for which he does not need his ten to 15 years training or his extensive experience in dealing with sick patients, that he barely has time to act in the area where he is an expert. He also has limited time for family, recreation, and continuing education; the very things that contribute so much to increased productivity in life and work.

Problems and a Solution

There are 270,000 practicing physicians in the U. S. today. Of the 110 medical schools, 20 or more are so new that they will not graduate any

students for three to four years. Any increase in physician numbers resulting from enlarged classes and new schools is still six to nine years away and then the maximum graduating number from all schools would be 15,000; today it is 11,000. This is approximately the number required to keep up with population and population age increase alone after making allowances for retirement and death of presently active physicians, and does not begin to meet the increased demand resulting from other factors.

With the present and future increase in the amount of work to be done by physicians and with the increasing disproportion between what the physician is capable of doing and what he actually does, is it any wonder that he does not go to the rural areas where there is no relief from demand and little opportunity for professional contact? There are 55 million people, 27% of the total U. S. population, in rural areas today. These are defined as geographic areas of 2,500 or less population. There are no physicians in these areas. Some of them are as big as counties. In fact, the U. S. has 134 counties without physicians and four of them are in Florida. Not only are these unserved areas but the services are thinly spread in other rural areas when you consider the following figures: Florida has a physician-patient population ratio of 1 to 760, but the 29 counties with populations of 20,000 or less have a ratio of 1 to 2,800.

These are our problems: increasing demand, need, expectations and acceptance of health care by a larger populace and a larger percentage of the populace; physicians overburdened with tasks, some of which do not require his expertise; insufficient number of physicians now and in the foreseeable future, and an understandable reluctance on the part of physicians to move to rural communities under the present circumstances.

Facing these facts and figures, and acknowledging the need of the patient for personal care in health matters, the physician's assistant concept has been promoted. Admittedly the physician's assistant, when employed properly, will derive satisfaction from the relationship. Some physicians see this as a threat—a usurpation of the physician-patient relationship—and it is. Question: How much worse would it be to share this abundant commodity with one who works with and for the physician than to be so regulated and legislated that the entire practice is unpalatable?

The retention of the singular possessive apostrophe in "physician's assistants" means that physicians will still (and justifiably, if their education continues) be the standard bearers of quality of health care delivery.

The concept is not new. We have been delegating tasks to office personnel for a long time. The excellent scrub technician in the operating room may barely know the essentials of reading and writing but performs a needed service excellently. The L.P.N. who literally runs the emergency room and the one R.N. who knows as much or more about the practical aspects of OB than an obstetrician are all examples of people with demonstrated interest and ability who have earned increased responsibility.

However, we do not need to inch forward by changing roles for existing health personnel; we need to leap forward. We need to take apart every single task we do and examine it for the contents of need for judgment, synthesis, and extensive knowledge and then to reexamine it for the circumstances in which it is performed. The dictum has been used: If it is repetitive, a person can be trained to do it without the extensive training of the physician.

The physician's assistant can fill the role the physician has been playing for at least 50% of what has been traditionally "physician activities." This does not even address the problem of maldistribution of health care directly. Indirectly, however, as the physician learns to delegate and adequately supervise activities he formerly thought no one else could perform; maldistribution may be subject to approach through physician's assistants.

That we are just seeing the edge of the void in health care delivery is evident from familiarity with practicing physicians in underserved areas. They are objecting strenuously to emergency room duty. In some cases they are quitting it; even at the risk of losing hospital privileges. They are accepting no new patients or families. The result for the mobile family, newcomer and those who cannot reach their own physician is medical disfranchisement. They will not, however, be politically disfranchised. Without active support by physicians and organized medicine for development and utilization of physician's assistants, the increasing public pressure for more accessible health services will surely result in undesirable emotional legislation.

▶ Dr. Henry, University of Florida College of Medicine, Gainesville 32601.

Florida Physicians Association, Inc.

James T. Cook, M.D. and Jack A. MaCris, M.D.

At the 1971 House of Delegates meeting, a resolution (71-4) was presented to the House and referred for study to the Board of Governors. This resolution proposed that the FMA "organize and sponsor a corporation dedicated to the private practice of medicine in Florida; that the membership of the corporation be restricted to FMA members and voluntary participation; and that the corporation be directly responsible to the FMA. The corporation will be known as the Florida Physicians' Association, Inc." The above is the final wording, to save space. The resolution was studied by a committee of the Board which recommended the implementation of the resolution, and this was affirmed by the 1972 House of Delegates, which also agreed with the Board of Governors that the FMA members be encouraged to join this Florida Physicians' Association (FPA).

The question is, of course, why should we have such an auxiliary organziation? Is there anything it can do that the FMA, the AMA, or the Florida Medical Foundation cannot do already? Is there anything it will do that the existing organizations can do but will not do? As Chairman, (JC) of the Ad Hoc Committee of the Board of Governors to implement this resolution, and as a member (JM) of the committee, we shall try to answer these questions. But first, let us tell you where we are now.

To date, we have written, and have had approved by the Board of Governors, a charter of incorporation. This was not easy, nor were all the decisions made by the committee or the Board of Governors unanimous. We had to write a charter with certain restrictions: restricted membership, voluntary participation, and directly responsible to FMA (this last was a source of long debate at the 1972 House of Delegates Meeting and was finally passed by a 2:1 majority). Also, in the area of "directly responsible," is a question of degree: we needed enough severance of organization (FMA and FPA) so that the one would not be legally responsible for the actions of the other and still be closely enough attached so that FPA would be and continue to be directly responsible to FMA. By the time this appears in print, the organization will be chartered with Dr. Cook as President, Dr. MaCris as Vice President, Dr. Paul C. Harding as Secretary, and Dr. Thad Moseley as Treasurer. These are interim appointments by the Board of Governors until an election can be held. More of the mechanisms later.

There must be a reason doctors need a new organization. The basic purpose, in frank terms, is to have an organization with teeth to arbitrate with third parties. By "teeth," we mean the ability to threaten these third parties with either non-cooperation with their programs, restricted cooperation, or other recourse. Unquestionably, the medical profession has been saddled with many unacceptable requirements by third parties, and all of us can envision even more of these to come. To name a few, the Medicare law itself; the restriction of fees to the 90th percentile and then arbitrarily lowering these to the 75th percentile; inadequate fees under Medicaid; extensive paper work in both programs; inadequate fees under Workmen's Compensation; the release of doctors names who made over $25,000 under Medicare with the implication they are not honest before they have a chance to defend themselves; the obnoxious label "more than allowable charge," and many, many more. These are, most of us believe, valid grievances. Ostensibly, we now have constructed an organization that will settle them, provided, of course, the doctors of the state will join and will abide by the decision of the leaders of the FPA.

The next question is, "Can the FPA do these things?" The Ad Hoc Committee has questioned the legal departments of nineteen major states,

Dr. Cook is temporary President of this association and Dr. MaCris, Vice President.

one specialty society, the Florida Physician's Guild, the AMA, and our own legal department. In a nutshell, the FPA can do nothing the AMA, the FMA, or the FMF cannot do *at this time*. As long as we remain self employed, as most doctors are, we cannot strike or indulge in any variation of a strike, no matter what we call it. We cannot recommend limited cooperation, non-cooperation, or any unified act in this field without strong risk of conviction under the Sherman Anti-Trust Act. Labor unions have a law giving them these rights, but the Sherman Anti-Trust Act, at present, prohibits us from utilizing these exemptions, even in a large group of doctors.

The attorneys of the Florida Physician's Guild, in an excellently prepared legal brief, think perhaps we have been running scared of the Sherman Anti-Trust Act, and that we might be able to get away with some of these actions. Of course, should we in FMA, to draw an example, advise all Florida physicians not to treat people under the Medicare law; should the FMA be indicted and arrested under the Sherman Anti-Trust Act with the potential triple damages allowed under the act, then the FMA would be broke and, indeed, defunct. The FMA has not been willing, with the advice of good attorneys, to take this risk.

Possibly, the new organization, the FPA, could afford to take the risks that FMA has not. The worst thing that could happen would be for the law to break up the organization financially and jail its officers. Anybody want the job? (JC and JM). Face the facts, there is absolutely nothing a new organization can do that we can't do already. These blandishments that other already existing organizations are pouring out to our members over the state, saying all these things they can do that the AMA and FMA cannot do, are poppycock. We still have to arbitrate with one hand behind our back, for we have no threat to answer the threats of loss of income, fine, or jail. All we can do is state what we believe is fair, good, or to the best interest to all concerned.

We note a union of doctors in Las Vegas which has arbitrated with SSA so that they pay for peer review expenses and time. FMA (through FMF) did this two years ago. Their arbitration power is not one whit greater than that of our existing structure, nor is it any better implemented.

There is one other major question: can and will FPA do things that FMA won't do? In our opinion, no. In all the grievances listed above, and in hundreds more, the AMA and FMA have been active in interceding and objecting. In many instances, we have been successful; on occasions we have been able to eliminate objectionable suggestions before they got even beyond the planning stage, and, unfortunately, before they came to the attention of all physicians. Because we lose a lot of battles does not mean we have not been fighting. Every new law, state and federal, that has application to either the scientific or the socio-economic side of medicine is carefully monitored and the position of the FMA and/or the AMA is made perfectly clear to the appropriate persons. The same is true for the regulations made by the various federal or state agencies. Unfortunately, the opinion of organized medicine does not always prevail.

One of us (JC) has been active in organized medicine for over twenty years, and the other, (JM) for fifteen years. To our accurate knowledge, no law or regulation has ever been "sneaked by" us. We can recall one hasty and ultimately possibly erroneous decision that was made; we can recall no areas of abysmal ignorance that a new organization can correct.

The proposal was made at a reference committee of the AMA that we get the Sherman Anti-Trust Act off our back by having it amended to exempt a physicians union. This would be great, but most of you realize this is practically impossible from a political standpoint. We can, however, anticipate with dread another change in the law. This is the possibility of the complete socialization of medicine. In that event, and should the implementation be in such a way as to make us employees of the state or federal government, we then could act as a union in the FPA. This is the raison d'etre of the FPA. We believe we should be ready with a viable organization with pledges of cooperation from most of Florida doctor members. Probably not before then, but certainly then, we will have our arm untied and be able to come out swinging. No really low blows, you understand, but there's nothing wrong with a couple to the solar plexus. But we want our gloves on before the gong sounds.

We are well aware of the splinter groups encouraging and often persuading doctors to join them, holding out the promises of political effectiveness and powerful arbitration not now available under any organization. These are, in our opinion, fatuous promises which they cannot carry out as well as is already being done. They only serve to deteriorate our present efforts, and are

predicated upon the anger and frustration and fears of physicians. The truth of the matter is that we lose many of our battles because we have only the arguments of what is right, or just, or good, or sound. Unfortunately, these arguments are often ineffective when balanced against those of what is politically expedient, what will attract the most votes, or is supported by the most re-election money. I hope the FPA can serve to better educate our members in practical politics in what can and cannot be done; this is certainly one of our goals.

We won't go far into the original charter. Basically, a Board of Directors is elected by the component county societies in each congressional district. FMA appoints three others, FLAMPAC one more. The Board elects the officers. At least ten percent of FMA members of a congressional district must be members to qualify to elect a member of the Board. We hope to have enough members by January to have a full election.

Finally, let us urge you to join. Annual dues at present are $15.00. This is a modest sum to be certain we're ready. We can see as a distinct possibility that at some time, a year or so from now, the FMA can and will say: "FPA, you have eighty percent of the members of FMA. The federal government has made us employees of the government, so you are now entitled to act as a union. The government is setting our fees at sixty percent of the usual and customary fee. We consider this inadequate. The FMA requests the FPA to negotiate in the behalf of FMA."

As with a new drug, the FPA cannot be a panacea. We have tried to develop for you what it can do and what it cannot do. The vaccine to prevent the disease is political, and our arm, in this instance, is AMPAC and FLAMPAC. The drug to fight the disease is FPA. We must have it fully effective before the disease becomes fulminant.

▶ Dr. Cook, 5th Avenue, Marianna 32446.

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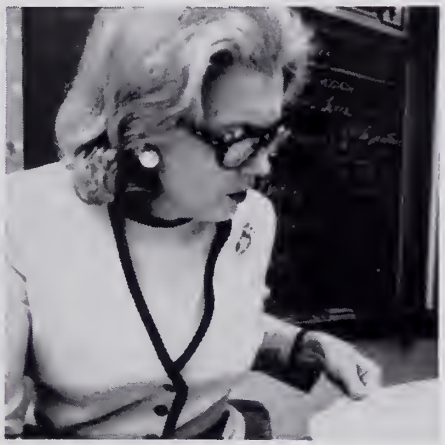
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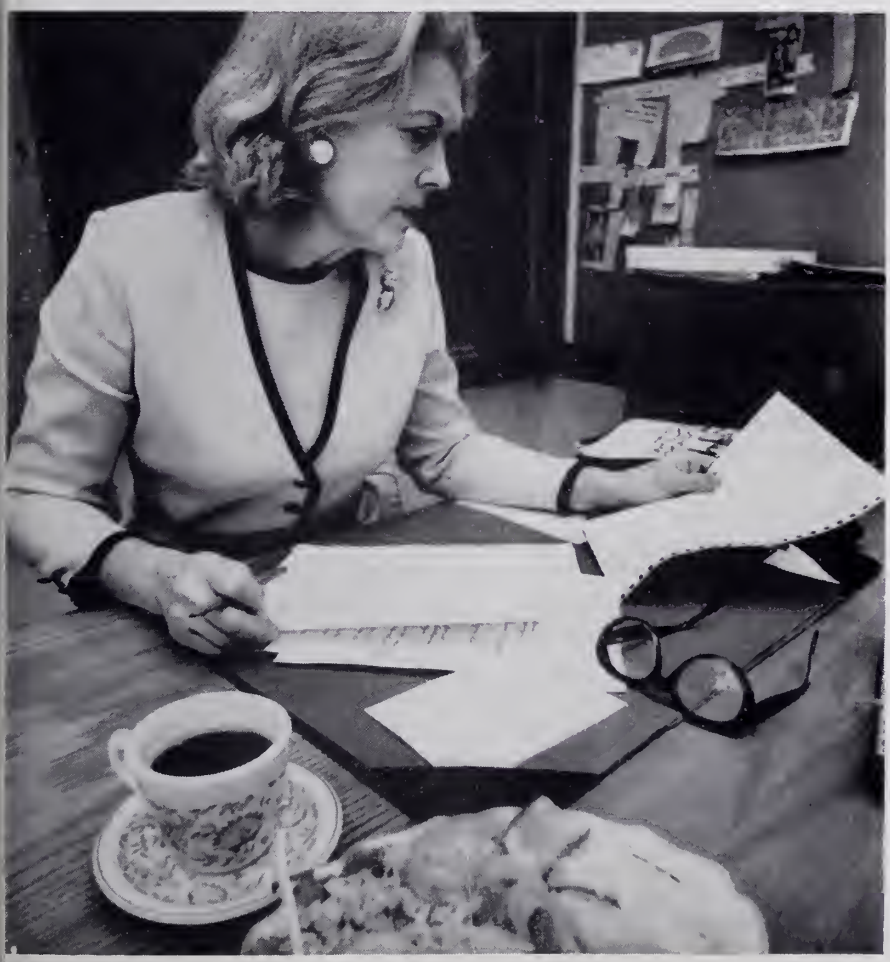
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Editorial

A Season for Hope

Like a gay shaft of sunshine, Christmas comes into the corners of our hearts, bringing its songs of faith and life, children's laughter, love and tenderness, trusting hearts and an intent to do something for others. Christmas is the greatest universal theme, offering clear proof that its intrinsic truths are the foundations of life, for as we say "Merry Christmas," "Happy Christmas," we are all born again in the spirit of Him whose birthday we commemorate. Nevertheless, many believe that the holiday has been blighted by materialism and that it is a phony, commercialized unhealthy day of overindulgence and accidents. However, those who want to take seriously this holiday can ignore the commercial segment of Christmas, although the spiritual part is harder to separate from the true message. False spirituality, mistaking form for substance, prayers for performance and worship for practice, entices us away from the year-round ministry of brotherhood, the true meaning of Christmas.

As families gather and homes are festively decorated, Christmas trees, with their fresh, spicy odors clear the air for us to see that Christmas is a season engaging the whole world in a conspiracy of love. Something happens to the quality of life at this time each year. Even hardened drifters buffeted by a callous world relive the hope and make believe of their childhood Christmases and feel stirring in themselves, long forgotten feelings of good will toward others.

Before the eye of one's imagination file bygone Christmas eves with happy family groups, lighted trees and stockings hanging before hearths. And one can further look backward ovér some nineteen hundred odd Christmas eves to see governments and civilizations crumble and pass away while the whole face of the earth has been transformed by manmade laws and machines. Why cannot we then transform for the better, human relations?

Some objective facts in the world today do favor optimism. Violence is disappearing from our campuses, our military forces are gradually being withdrawn from Southeast Asia and the great powers sit face to face discussing armament limitations. At least a cheerful view of life should be permitted on one day of the year, for unrelieved pessimism is a corrupt and destructive force. The light of peace which is permitted to shine more brightly at this time of the year is the only hope for our trouble-torn world. In the pursuit of material success, we too often forget that man does not live by bread alone, that there are spiritual, intangible, imponderable values more powerful than all the fortresses of hate.

It is easy to think Christmas and easy to believe Christmas but it is hard sometimes, intolerably hard, to act Christmas. This is, all year long, being a friend to someone lonely, lighting a candle of joy to melt a bitter heart, obeying one's finer impulses and being steadfast in one's prayers for peace. When man begins to understand, he will learn to love and when his love is understood, there will be everlasting peace, for the only hope for peace is understanding. Two thousand years ago, they were hoping for a mighty king, a man of power but Mary brought forth a baby, a child to lead us to the light. The hope of peace on earth illuminated so long ago still seems a distant goal and yet, this is Christmas, a time to renew the hope and faith that someday throughout the world all will live as friends and neighbors. Would we be so wrong if we saw in the Star's half-light the beginning of a new dawn rather than the coming of the night?

C.M.C.

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ORGANIZATION

Recognition for a Health Director

J. Basil Hall, M.D.



Dr. Hall in his office. Photograph in background is the actual blastoff to the moon, autographed personally to Dr. Hall by Neil Armstrong, Mike Collins and "Buzz" Aldrin upon their return.

Dr. J. Basil Hall became director of the Lake County Health Department in 1949. Early this year he indicated his intention to retire, made it official in June and then late in September a time of fellowship with his staff ended a quarter century in preventive medicine and public health. It had begun in October 1946 in the district health department at Vero Beach and spanned service as director of the Highlands-Glades County Health Department and as director of the Florida State Board of Health's Cancer Control Program.

As the 11th director in the previous nine years, Dr. Hall remarked he had inherited many unresolved problems in Lake County caused by the "lack of continuity." He encouraged home ownership and civic affairs participation among his staff because this was convincing evidence of permanency. He maintained that people tended to have confidence in the man who looked like he intended to stay in one place.

During the longest continuous service as a county health director in the State, Dr. Hall built up an outstanding department. Almost a decade ago its record of accomplishments reached as far as New York State and the commissioner of health visited Dr. Hall to witness operations first hand. The Samuel J. Crumbine Awards Jury commended the department "for a truly outstanding program of achievement in development of a comprehensive sanitation program." It cited the work of sanitarians, mosquito control personnel and the nursing staff. The booklet on care of teeth among school children reprinted by the State Department of Education originated with Dr. Hall's staff. The Lake County Dental Society presented him its certificate of appreciation for his work

with dental clinics.

Dr. Hall served as president and as secretary-treasurer of the Lake County Medical Society, (first county health director ever so honored), and maintains that preventive medicine and curative medicine can "stay in step and shoulder to shoulder." Required is a two-way channel of communications with rarely a break in continuity. He wrote:

"The health officer must be cognizant of the fact that the difference is only in degree—percentage if you will. The private physician is dealing with and spending 95 per cent of his time with disease (not because he prefers it that way, but of necessity) while we spend 95 per cent of our time with wellness and in attempting to keep people well."

Concerned about poor attendance at Society meetings while serving as secreary-treasurer, Dr. Hall hit upon what "Medical Economics" described as a "ten-point plan bristling with bright ideas" which resulted in 88% of members attending. "We Pack 'Em in at Our Medical Meetings" published by "Medical Economics" told how it was done and won Dr. Hall an award.

He has represented the Society as a delegate to the Florida Medical Association's House of Delegates for many years, and served as chairman of various FMA committees. He was vice president of the Florida Academy of General Practice and president of the Florida Health Officers Society. The American Medical Association invited him to its first Congress on Mental Health and selected him as a member of the advisory board to the Sears-Roebuck Foundation.

A newspaper reporter commented upon his "keen sense of humor" when he retired after 30 years as a medical officer in the Air Force Reserves. A colonel, he served as a flight surgeon for three years in the Pacific theatre during World War II and was awarded nine battle stars, a President's Citation with one Oak Cluster along with other medals. He is credited with gaining acceptance of Atabrine for prevention of malaria among troops in the area.

His humor is evident in an article for the May 1964 Florida Medical Association Journal. ". . . . I am led to believe that the outstanding man of the twentieth century will not be an astronaut, a moonnaut, a son-of-a-naut, a general, a scientist, nor a politician, but simply a practical business man who can give us a balanced federal budget, pay 1 per cent on our national debt annually and continue to be reelected year after year. I fear that such a man is yet unborn and that his mother is already dead."

Throughout the years Dr. Hall's paramount interest has been the health of the people in Lake County. He has advised them about many things: outdoor privies, mad dogs, mosquitoes, inoculations for foreign travel, nuclear warfare dangers, and citrus as fertilizer. "In using citrus as fertilizer," he wrote, "bury it in a trench no farther out than where the branches reach. This not only gives nourishment to the trees but it also eliminates a sanitation problem."

A native of Tennessee, Dr. Hall received the doctor of medicine degree from the University of Tennessee College of Medicine and the Master of Public Health degree from the University of California at Berkeley. He was graduated from the School of Aviation Medicine at Randolph Field in Texas and has studied the medical aspects of radiation. He is a consultant on aviation accidents, member of the Federal Aviation Agency for examining pilots and Aerospace Medical Association. He is certified by the American Board of Preventive Medicine and a founding member of the American College of Preventive Medicine.

Dr. and Mrs. Hall's home in Mount Dora fronts on Lake Dora. They have one son, Lt. Jim, a Vanderbilt honor graduate (Phi Beta Kappa), now completing his deferment obligation at Fort Benning, Georgia.

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Not keeping up could lose you a malpractice suit if the first proposal of the Commission on Medical Malpractice jells. The commission voted that continuing education should be required of physicians, and will work to set standards. Once it does, the threat of malpractice suits will multiply for doctors who don't keep up.

Reprinted from Medical Economics, September 1972.

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Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)
All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.
Tetracyclines are present in milk of lactating women taking tetracyclines.
To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The antianabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.
Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal diseases, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis inflammatory lesions (with monilial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.
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Medical News

Dr. Irwin Gets New BC-BS Post

The organization of a Florida Blue Cross and Blue Shield Medical Division and the appointment of a Jacksonville physician to head it have been announced by President J. W. Herbert of Jacksonville.

Thomas M. Irwin, M.D., a longtime practicing otolaryngologist prior to joining Blue Shield full time three years ago, has been named Medical Director of the new unit. Mr. Herbert said Dr. Irwin would be responsible for providing medical expertise and consultation to all corporate functions where required.

Dr. Irwin is a member of the Florida Medical Association and is a former President of the Duval County Medical Society.

New Surgery Faculty Members

Two physicians recently received faculty appointments in the Department of Surgery of the University of Miami School of Medicine.

Robert Zeppa, M.D., Professor and Chairman of the Department, announced that Everard F. Cox, M.D., had been appointed a Professor of Surgery, and Joseph M. Civetta, M.D., was named Associate Professor of Surgery and Anesthesiology.

Dr. Cox is a Utah native who most recently was associated with St. Agnes Hospital in Baltimore. He received his M.D. degree at the University of Baltimore and received his surgical training there. At Miami, he will direct the Tumor Clinic at Jackson Memorial Hospital, the School's teaching institution.

Dr. Civetta will direct the Surgical Intensive Care Unit at Jackson. He went to Miami from Boston, where he was on the staff of Massachusetts General Hospital and served as an instructor at Harvard Medical School. He received his M.D. degree at Boston University School of Medicine.

Anesthesiologists Elect Dr. Moya

Frank Moya, M.D., of Miami, was elected First Vice President of the American Society of Anesthesiologists during the ASA's Annual Meeting in Boston.

Dr. Moya is a native of New York City and serves as Chairman of the Department of Anesthesiology at the University of Miami School of Medicine. He is a graduate of the State University College of Medicine in New York City, a Diplomate of the American Board of Anesthesiology, a Fellow of the American College of Anesthesiologists and a member of the Florida Medical Association.

Dr. Grady Heads AAPS

John L. Grady, M.D., of Belle Glade, has been named the first President of the Florida Branch of the Association of American Physicians and Surgeons.

Other officers of the Florida AAPS group, chosen in a statewide ballot, are: Paul E. Brady, M.D., St. Petersburg, Vice President; Ronald M. Wilson, M.D., Orlando, Secretary; and Francis M. Coy, M.D., Orlando, Treasurer.

ASA Honors Dr. Papper

Emanuel M. Papper, M.D., Vice President for Medical Affairs and Dean of the University of Miami School of Medicine, has received the distinguished service award of the American Society of Anesthesiologists.

Dr. Papper received the award at the 11,500-member ASA's Annual Meeting in Boston on October 1. He is a former President of the Society and the American Board of Anesthesiology and is the author of more than 220 scientific papers and five books.

A native of New York City, Dr. Papper is a 1935 Phi Beta Kappa graduate of Columbia University and received his M.D. degree in 1938 from New York University.

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MEETINGS

Approved by FMA Committee on Continuing Education

DECEMBER

7 GULF COAST HEALTH CONFERENCE —FAMILY PLANNING 1972, Pinellas County Health Department Auditorium, St. Petersburg. (No registration fee). Participants are: Dr. William Spellacy, Miami; Dr. James Ingram, Tampa; Dr. John Daly, Gainesville; Dr. Coy Lay, Lakeland and Dr. O. Thomas Bolding, Birmingham, Alabama.

8-10 "The Spinal Cord Injured Patient," from the Department of Orthopaedics and Rehabilitation, University of Miami School of Medicine, Americana Hotel, Miami Beach. For information: Augusto Sarmiento, M.D., Box 875, Biscayne Annex, Miami 33152.

13-15 Twelfth Biennial Cardiovascular Seminar—"Complications of Myocardial Infarction," Doral Hotel, Miami Beach. For information: Marvin L. Meitus, M.D., 5080 Biscayne Blvd., Miami 33137.

JANUARY

5- 7 International Symposium on Acupuncture, Tides Hotel & Bath Club, Redington Beach, St. Petersburg. For information: John C. McCamy, M.D., Box 3164, Seminole, Florida 33542.

9-13 Radiological Special Procedures—Basic and New Information, Playboy Plaza Hotel, Miami Beach. For information: Manuel Viamonte Jr., M.D., Box 875, Biscayne Annex, Miami 33152.

13 Postgraduate Seminar in Surgery-Art and Science in the Therapy of Difficult Problems in Surgery, Eden Roc Hotel, Miami Beach. For information: Robert Zeppa, M.D., University of Miami School of Medicine, Box 875, Biscayne Annex, Miami 33152.

14-16 Infectious Diseases 1973: Treatment and Prevention, Eden Roc Hotel, Miami Beach. For information: Frances Richardson, Mt. Sinai Hospital, 4300 Alton Road, Miami Beach 33140.

National and Regional Meetings Held in Florida

DECEMBER

1- 2 American College of Chemosurgery, Balmoral Hotel, Miami, Sec.-Treas.: Richard S. Moraites, M.D., 7721 Montgomery Rd., Cincinnati, Ohio 45236.

2- 7 American Academy of Dermatology, Americana Hotel, Miami Beach. Sec.-Treas.: Frederick A. J. Kingery, M.D., 2250 Northwest Flanders Street, Portland, Oregon 97210.

3- 6 American Society of Hematology, Diplomat Hotel, Miami Beach. Sec.: Steven Robinson, M.D., Beth Israel Hospital, 330 Brookline Avenue, Boston 02215.

4- 6 Southern Surgical Association, Boca Raton Hotel, Boca Raton, Sec.: David C. Sabiston Jr., M.D., Duke University Medical Center, Durham, N.C. 27710.

1973

MAY

21-24 American College of Obstetricians and Gynecologists, Americana Hotel, Miami Beach. Dir.: Michael Newton, M.D., 79 West Monroe Street, Chicago 60603.

JUNE

11-15 Society of Nuclear Medicine, Americana Hotel, Miami Beach. Exec. Dir.: Mrs. Margaret Glos, 211 East 43rd Street, New York 10017.

OCTOBER

21-25 American Society of Plastic and Reconstructive Surgeons, Diplomat Hotel, Miami Beach. Exec. Vice-Pres.: Mr. Dallas F. Whaley, 29 East Madison, Chicago 60602.

NOVEMBER

8-10 Gerontological Society, Deauville Hotel, Miami Beach. Exec. Dir.: Mr. Edwin Kaskowitz, 1 Dupont Circle, Washington, D.C. 20036.

11-16 American Association of Blood Banks, Americana Hotel, Miami Beach. Central Office Manager: Miss Lois J. James, 30 North Michigan Avenue, Chicago 60602.

DOCTOR, MARK THESE

DATES ON YOUR CALENDAR:

MAY 9-13, 1973

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Reprinted from American Medical News, August 7, 1972.



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Books Received

Receipt of the following books is acknowledged. While time and space will not permit review of all books received, medical readers interested in reviewing particular books are invited to address requests to the Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.—Ed.

Cardiovascular Physiology, Second Edition, by Robert M. Berne, M.D. and Matthew N. Levy, M.D. Pp 265. 193 Illustrations. Price $9.25. St. Louis, The C. V. Mosby Company, 1972.

Hematopoietic and Gastrointestinal Investigations with Radionuclides by Albert J. Gilson, M.D., William M. Smoak III, M.D. and Morton B. Weinstein, M.D. Pp. 456. Illustrated. Price $30. Springfield, Ill., Charles C. Thomas, Publisher, 1972.

Synopsis of Pathology, Eighth Edition by W. A. D. Anderson, M.D. and Thomas M. Scotti, M.D. Pp. 1076. 433 Illustrations. Price $13.95. St. Louis, The C. V. Mosby Company, 1972.

A Civilian Doctor in Vietnam by Fred Gloeckner, M.D. Pp. 123. 27 Illustrations. Price $5. Philadelphia, Pa., The Winchell Company, 1972.

Mental Health Training and Public Health Manpower by Stephen E. Goldston, Ed. D., M.S.P.H. and Elena Padilla, Ph.D. Pp. 294. Price $2.75. Rockville, Maryland, National Institute of Mental Health, 1971.

Malnutrition, Its Causation and Control, Volume I and II by John R. K. Robson. Pp. 613. Illustrated. New York, Gordon and Breach, Science Publishers, Inc., 1972.

Current Pediatric Diagnosis Treatment, 2nd Edition, by C. Henry Kempe, M.D., Henry K. Silver, M.D. and Donough O'Brien, M.D. Pp. 1008. Illustrated. Price $12.00. Los Altos, California, Lange Medical Publications, 1972.

A Synopsis of Contemporary Psychiatry, Fifth Edition by George A. Ulett, M.D. Pp. 367. Illustrated. Price $10.90. St. Louis, The C. V. Mosby Company, 1972.

Symposium on Aesthetic Surgery of the Face, Eyelid, and Breast, Volume Four. Edited by Frank W. Masters, M.D. and John R. Lewis Jr., M.D. Pp. 222. 446 Illustrations. Price $35.50. St. Louis, The C. V. Mosby Company, 1972.

A Laboratory Manual for Exercise Physiology by Donald J. Byrd, Ph.D. and Freddie M. Browning, Ph.D. Pp. 158. Springfield, Illinois, Charles C. Thomas Publisher, 1972.

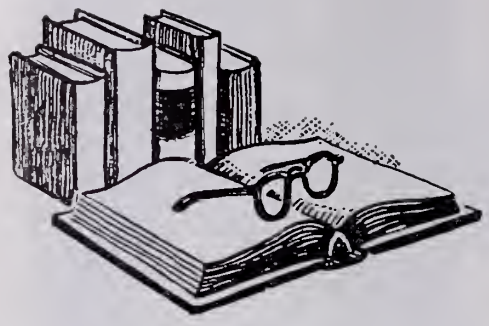


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Book Reviews

The Patient's Progress edited by Felix Marti-Ibanez, M.D. Pp. 137. New York, MD Publications, Inc., 1972.

A delightful literary gem by the late editor-in-chief of MD, the medical news magazine, outlines the history of mankind in this history of the patient's progress from prehistoric era to modern times. A group of editorial essays as philosophical preludes, introduces each chapter of the sociology of medicine proclaiming that the "physician today must aspire to heal not the sick man but the man sick, always offering him relief, counsel and guidance for his return to the society from which his ailment has isolated him."

Beginning with the Mesopotamian civilization, disease was described as punishment by the gods for mortal sins and the sufferer was regarded as a sinner. Diagnosis was based on interrogation of the patient to seek out his mortal sin. If this method failed, observation of the bleeding of animals, the course of the heavenly bodies, or the study of birds in their flight was used to confirm the healer's initial impression. In the Neanderthal period, hunters, users of fire, and makers of chipped pebble goods attended their wounded, crippled and aged and ritually buried their dead. In his reliance on religion, the Egyptian physician recognized the power of the gods to heal or destroy but also accepted the responsibility of using skill and knowledge in their patients' behalf, so, for the first time, a sick man experienced the comfort of a personal relationship with his physician. The world of Gothic medicine is described lucidly as are the nine crusades.

The most inspiring chapter entitled "The Brave Samaritan" describes the progress of the physician and his status through the ages. In it the author tells how "in Hippocrates' time, physicians traveled from place to place, recruiting their patients and, for centuries, medical theory was eminently religious. Today, modern medicine lacks religion and philosophy, and its shortcomings stem from the lack of interest in the history of medicine, the lack of a philosophical theory of disease and of the physician's mission. As medicine is not an exact science, the unpredictable stress and vexations of personal reactions tests the caliber of the physician who must stimulate the patient to have faith in himself and his doctor. Such faith is worth as much as the medicine administered. The physician must be courteous and gentle and must know when to withhold the truth from his patient. The physician's professional culture must be based on integrity." The physician, whose profile is sketched here, is the true physician to treat the patient of today. His first love is the practicing of his profession but he also loves his patients, his family and his fellowmen. Because of his dedication, he knows that even when he dies, his influence will not disappear altogther for through his work his dreams will endure forever.

This short history teaches personal modesty and austerity and describes the continuity and tradition of medical practice. Any physician who aspires to more adequately follow "The Patient's Progress" in his own practice will enjoy this book.

C.M.C.

The Understanding Physician, Writings of Charles D. Aring, M.D. Pp. 215. Price $8.95. Detroit, Wayne State University Press, 1971.

These selected writings of Dr. Charles Aring, senior neurologist at the University of Cincinnati, were originally issued by that university in tribute to his half century of association with that institution. This volume adds three new essays and the author's preface.

Many readers are already familiar with Dr. Aring's thoughtful, sensitive, articulate essays. My favorite is "Intimations of Mortality, An Appreciation of Death and Dying" which was published in Annals of Internal Medicine 60:137-152, 1968. In this essay, he quotes from Harvey Cushing's biography of Sir William Osler, the beautiful, tender story of Osler's relationship with a dying child and her family.

Another penetrating essay entitled "Senility, Its Nature, With Some Thoughts Concerning Treatment and Prevention" was originally published in Archives of Internal Medicine 100:519-528, 1957. It was recently published, in slightly revised form, in Annals of Internal Medicine.

This book is recommended for those physicians who wish to have Dr. Aring's writings in a single volume. It might be a thoughtful gift for a colleague, a deserving student, or house officer. I am glad to have it in my library.

F. Norman Vickers, M.D.
Pensacola

Review of Physiological Chemistry by Harold A. Harper, Ph.D. Pp. 529. Illustrated. Price $8.00. Los Altos, California, Lange Medical Publications, 1971.

The author is professor of biochemistry at the University of California Medical School as well as a consultant to various hospitals.

This is the 13th edition of the Review, which is published not only in the United States but in many foreign countries. Constant reviews allow updating of material from new contributions, which is a never ending job to try to pick out what is valuable and pertinent for inclusion.

The book discusses carbohydrates, lipids, proteins, vitamins, the functions and chemistry of body cells, fluids, gases, and the metabolism of various systems and tissues, and is written in a clear, very readable style.

The illustrations and formulae are well presented. There is a chapter on Calorimetry and the Elements of Nutrition, and an appendix of General, Physical, and Organic Chemistry. These are very helpful for the individual who wants a quick review of the subjects. The book is highly recommended and the price is right in an age of skyrocketing inflation.

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